

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

JOHN HANCOCK LIFE INSURANCE
COMPANY, JOHN HANCOCK
VARIABLE LIFE INSURANCE
COMPANY and MANULIFE
INSURANCE COMPANY,

Plaintiffs,

v.

ABBOTT LABORATORIES,

Defendant.

CIVIL ACTION NO. 05-11150-DPW

**ABBOTT'S CORRECTED DEPOSITION DESIGNATIONS AND
COUNTER DESIGNATIONS FOR JESSICA HOPFIELD**

Defendant Abbott Laboratories ("Abbott") respectfully submits the attached corrected deposition designations and counter-designations for the November 2, 2006 and May 8, 2007 depositions of Jessica Hopfield, Principal at McKinsey & Co, Inc.

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Dated: February 21, 2008

Respectfully submitted,

ABBOTT LABORATORIES

By: ___/s/ Eric J. Lorenzini_____
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CERTIFICATE OF SERVICE

I hereby certify that this document(s) filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non registered participants on February 21, 2008.

Date: February 21, 2008.

/s/ Ozge Guzelsu

Jessica Hopfield Deposition Designations

Depo Date	Witness	Hancock Designation	Abbott Counter Designation	Abbott Designation	Deposition Exhibit	Plaintiff Exhibit	Defendant Exhibit
06/18/07	Hopfield, Jessica	4:2-4:14					
06/18/07	Hopfield, Jessica	8:10-12:12					
06/18/07	Hopfield, Jessica	16:4-19:12					
06/18/07	Hopfield, Jessica	19:22-20:22					
06/18/07	Hopfield, Jessica			20:23-24:5			
06/18/07	Hopfield, Jessica	24:6-25:12					
06/18/07	Hopfield, Jessica	39:19-40:22	40:23-41:8				
06/18/07	Hopfield, Jessica			41:9-42:5			
06/18/07	Hopfield, Jessica	42:20-43:9					
06/18/07	Hopfield, Jessica			43:23-44:5			
06/18/07	Hopfield, Jessica	44:12-45:7					
06/18/07	Hopfield, Jessica	46:19-49:7					
06/18/07	Hopfield, Jessica	50:1-50:22					
06/18/07	Hopfield, Jessica			52:6-55:8			
06/18/07	Hopfield, Jessica	74:12-75:8	75:9-75:12		4	FC	
06/18/07	Hopfield, Jessica	78:6-81:11	81:12-81:18		4	FC	

Depo Date	Witness	Hancock Designation	Abbott Counter Designation	Abbott Designation	Deposition Exhibit	Plaintiff Exhibit	Defendant Exhibit
06/18/07	Hopfield, Jessica	81:20-82:5	82:6-82:12		4	FC	
06/18/07	Hopfield, Jessica			82:18-84:19			
06/18/07	Hopfield, Jessica			85:1-86:24			
06/18/07	Hopfield, Jessica	87:1-89:7	89:8-89:12		5	FH	
06/18/07	Hopfield, Jessica	90:17-91:20	91:21-92:19		5	FH	
06/18/07	Hopfield, Jessica	95:5-96:12	96:13-98:18		5	FH	
06/18/07	Hopfield, Jessica	98:20-102:15	106:16-106:21		5	FH	
06/18/07	Hopfield, Jessica	103:4-105:15	105:16-105:22		6	GW	
06/18/07	Hopfield, Jessica	107:1-109:4			7	FI	
06/18/07	Hopfield, Jessica	110:13-111:21			7	FI	
06/18/07	Hopfield, Jessica	116:6-118:1	118:2-118:13		8 9 10 11	FL FM FR FS	
06/18/07	Hopfield, Jessica	125:1-127:12	124:20-124:24				
06/18/07	Hopfield, Jessica		127:13-127:20				
06/18/07	Hopfield, Jessica	133:24-134:22	134:23-136:22		8	FL	
06/18/07	Hopfield, Jessica			137:9-140:22			
06/18/07	Hopfield, Jessica			141:11-142:1			
06/18/07	Hopfield, Jessica			145:9-146:4			

Depo Date	Witness	Hancock Designation	Abbott Counter Designation	Abbott Designation	Deposition Exhibit	Plaintiff Exhibit	Defendant Exhibit
06/18/07	Hopfield, Jessica	149:18-149:24			10	FR	
06/18/07	Hopfield, Jessica	155:2-156:19			11	FS	
06/18/07	Hopfield, Jessica			159:18-160:19			
06/18/07	Hopfield, Jessica	161:5-162:24			10	FR	
06/18/07	Hopfield, Jessica	166:2-166:22			11	FS	
06/18/07	Hopfield, Jessica			168:17-169:18			
06/18/07	Hopfield, Jessica			209:7-210:6			
06/18/07	Hopfield, Jessica			210:8-215:3			
06/18/07	Hopfield, Jessica	215:4-217:2	217:3-218:3		5	FH	
06/18/07	Hopfield, Jessica			218:4-229:13			
06/18/07	Hopfield, Jessica			229:16-232:24	23	GJ	

Color Key to Deposition Designations

 **Designation by Plaintiffs**

 **Counter Designation by Defendants**

 **Designation by Defendants**

Hopfield, Jessica (Linked) 6/18/2007 1:01:00 PM

1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE DISTRICT OF MASSACHUSETTS
3
4 JOHN HANCOCK LIFE INSURANCE)
5 COMPANY, JOHN HANCOCK VARIABLE)
6 LIFE INSURANCE COMPANY, f/k/a)
7 INVESTORS PARTNER INSURANCE)
8 COMPANY,)
9 Plaintiff,) 05-11150-DPW
10 vs.)
11 ABBOTT LABORATORIES,)
12 Defendant.)

13
14 The deposition of JESSICA HOPFIELD, called
15 for examination, taken before KATRINA WRIGHT,
16 CSR No. 84-3639, a Notary Public within and for
17 the County of Cook, State of Illinois, and a
18 Certified Shorthand Reporter of said state, at
19 Suite 1300, Two North LaSalle Street, Chicago,
20 Illinois, on the 18th day of June, A.D. 2007, at
21 1:01 p.m.

22

23

24

1 swear in the witness, please.

2 (WHEREUPON, the witness was duly

3 sworn.)

4 JESSICA HOPFIELD,

5 called as a witness herein, having been first duly

6 sworn, was examined and testified as follows:

7 EXAMINATION

8 BY MS. TROAKE:

9 Q. Ms. Hopfield, could you state your full

10 name for the record, please.

11 A. Jessica Hopfield.

12 Q. And your home address?

13 A. 333 West North Avenue, Chicago,

14 Illinois.

15 Q. And, Ms. Hopfield, I just want to go

16 over a few of the ground rules for the deposition

17 today. If for whatever reason you don't hear a

18 question that I ask, please ask me to repeat it.

19 If you answer a question, I will assume you heard

20 me. Is that okay?

21 A. Yes.

22 Q. If you don't understand a question,

23 just ask me to clarify it and I will try to do

24 that. Again, if you answer the question, I will

1 Q. -- on those occasions?

2 Were you an expert witness?

3 A. No.

4 Q. And where were those depositions?

5 A. At Merck.

6 Q. And was Merck a party to a lawsuit?

7 A. Yes.

8 Q. Have you ever testified at trial?

9 A. No.

10 Q. And, Ms. Hopfield, you are currently
11 employed at McKinsey; is that right?

12 A. Yes.

13 Q. Is that in Chicago?

14 A. Yes.

15 Q. What is your current role at McKinsey?

16 A. I am a principal, which is a
17 designation that means partner.

18 Q. And as a principal at McKinsey, what do
19 you do?

20 A. I have responsibility for leading
21 individual client engagements. I oversee more
22 broadly the relationship we have with our clients.
23 And I play a number of leadership roles in the
24 firm on internal issues.

1 Q. Do you head up any particular practice
2 area?

3 A. Yes. I co-lead our marketing efforts
4 in our pharmaceuticals and medical products
5 practice.

6 Q. And how long have you been responsible
7 for that practice group?

8 A. Two years.

9 Q. So since 2005?

10 A. Yes.

11 Q. Prior to 2005, were you responsible for
12 any other practice group?

13 A. No.

14 Q. When did you become a principal at
15 McKinsey?

16 A. 2001.

17 Q. And did you work at McKinsey prior to
18 2001?

19 A. Yes. I was an associate for five and a
20 half years.

21 Q. And were you assigned to a particular
22 practice area while you were an associate?

23 A. We don't assign, but, yes, I was
24 affiliated with our pharmaceutical and medical

1 products practice.

2 Q. Any other positions at McKinsey, other
3 than an associate and principal?

4 A. No.

5 Q. What did you do prior to joining
6 McKinsey?

7 A. I was at Merck & Company, the
8 pharmaceutical company.

9 Q. And what did you do for them?

10 A. I was in three different roles: in
11 marketing, in clinical development, and in their
12 project planning and management function.

13 Q. How long did you work at Merck?

14 A. Two years.

15 Q. And were you doing each one of those
16 roles during that entire time or did you have each
17 of those roles at different times during that
18 two-year period?

19 A. They were at different times. They
20 were sequential.

21 Q. What did you do prior to joining Merck?

22 A. I was a student at Harvard Business
23 School.

24 Q. When did you graduate from Harvard?

1 A. 1993.

2 Q. And prior to that?

3 A. I was a post-doc at Rockefeller
4 University.

5 Q. Where is Rockefeller University?

6 A. New York City.

7 Q. And prior to that, what did you do?

8 A. I was a Ph.D. student at that same
9 university.

10 Q. Where did you get your undergraduate
11 degree?

12 A. Yale.

13 Q. What was that in?

14 A. In biology.

15 Q. When did you get that degree?

16 A. 1986.

17 Q. Okay. At what point in 2001 did you
18 become a principal at McKinsey?

19 A. I was elected in mid December and that
20 would have been effective, if I remember
21 correctly, the beginning of 2002.

22 Q. So from January to December of 2001,
23 you were an associate?

24 A. I'm sorry. I made an error. I would

1 have been elected a principal in December of 2000.

2 That would have been effective in January of 2001.

3 Q. Okay. Did you supervise other people

4 at McKinsey as the head of the pharmaceutical and

5 medical products group?

6 A. Yes.

7 Q. Who did you supervise during 2001 in

8 that group?

9 A. Well, at that time, I was a member of,

10 as opposed to leading the practice. The people I

11 would supervise would be associates on my various

12 engagement teams.

13 Q. Are you aware of McKinsey ever doing

14 any consulting work for ManuLife or John Hancock?

15 A. I am not aware of it.

16 Q. We were talking just a minute ago about

17 how you looked for documents. You say you checked

18 your office files, hard drive, which included

19 e-mails.

20 Did you ever use a laptop while you

21 were working at McKinsey?

22 A. My laptop is my hard drive. I do not

23 have another computer.

24 Q. And the laptop you currently have, have

1 Q. What about hard copies that they might
2 have had in their files?

3 A. I don't know.

4 Q. When did you first become involved with
5 the engagement with respect to Abbott
6 Laboratories?

7 A. This would have been late 2000, when we
8 were starting to propose on supporting them
9 overall in the Abbott-Knoll pharmaceutical merger.

10 Q. And who at McKinsey was involved in the
11 services that were provided to Abbott in relation
12 to that engagement?

13 A. That engagement was overall led by
14 Richard Ashley, the individual you mentioned
15 earlier. As what we call our director of client
16 service, that was the most senior partner. David
17 Keeling was a more junior partner at the time who
18 had responsibility for the overall effort. And
19 then there were several other partners involved in
20 specific topic areas.

21 Q. And who were they?

22 A. I was one in R&D. I actually cannot
23 recall the complete set. There was Martin Lutz in
24 Germany, but I cannot recall the rest of the

1 partners involved.

2 Q. What about people other than partners?

3 A. The primary people that I recall were

4 Michael Williams, who was an associate principal

5 at the time -- that's a role right below

6 partner -- who was working on R&D with me. Doane

7 Chilcoat, who we just described before. There

8 would have been assigned to the study a number of

9 associates. I can't recall who they were. But we

10 had a team probably across all of the activities

11 of something like 15 to 20 people. But I had

12 interaction with only a few.

13 Q. And the people you had interactions

14 with, are those the ones that you mentioned or are

15 there others you had interactions with?

16 A. That is the core set.

17 Q. How did you become involved with the

18 engagement of McKinsey by Abbott?

19 A. Richard Ashley was leading the

20 development of our proposal to support them on the

21 merger. It was competitive with another

22 consulting firm, and as part of the what we call a

23 beauty contest, the two companies coming in and

24 describing what they would do, I was pulled in to

1 be an R&D expert. And so I was involved in some
2 of the later meetings as we were getting close to
3 having the engagement confirmed.

4 Q. And do you know when the engagement was
5 confirmed?

6 A. I don't recall, but it would have been
7 in the late 2000, early 2001 timeframe, but I do
8 not recall the date.

9 Q. What was the scope of the services that
10 McKinsey was hired to provide in connection with
11 the Abbott-Knoll integration?

12 A. We were hired to overall manage and
13 co-lead with them the integration of the two
14 companies, which had a number of components, the
15 prime area of which was ensuring Day 1, the day of
16 the new legal entity went smoothly, to help design
17 the new organization in terms of structure, and to
18 coach and counsel the senior executives from both
19 companies through the transition period.

20 Q. Design the new organization, coach and
21 counsel senior management through the transition
22 period --

23 A. And then prepare for Day 1.

24 Q. Okay. Thank you.

1 Do you recall when Day 1 was?

2 A. No.

3 Q. And Day 1 being the first day of the

4 new --

5 A. Legal entity.

6 Q. Do you recall how long the engagement

7 lasted?

8 A. Roughly six months.

9 Q. So if it started in December, January,

10 2000, 2001, it was completed by June or July of

11 '01?

12 A. By June or July.

13 Q. Do you recall doing any work for Abbott

14 on behalf of McKinsey after, say, the 4th of July,

15 2001?

16 A. I don't know, because they became an

17 active client on other issues. I believe we

18 finished our formal support of the overall

19 integration by early summer. I cannot recall

20 whether we had some smaller follow-on studies in

21 part of the engagement.

22 Q. Is McKinsey currently doing any work

23 for Abbott?

24 A. Yes.

1 Q. Are you personally involved in that?

2 A. No.

3 Q. What was your particular role in
4 relation to the services provided by McKinsey?

5 A. My particular role was to lead the R&D
6 work stream.

7 Q. What does that mean, lead the R&D work
8 stream; is that what you said?

9 A. Yeah. Because in a merger there are a
10 lot of functional areas that are impacted. We
11 divided ourselves up into a number of focused
12 teams, both the McKinsey folks and the client to
13 design and organize that function. And my
14 responsibility was to oversee that for R&D.

15 There were similar teams that were
16 working on issues of commercial integration, some
17 of the European sites and a number of other
18 functional or geographic axes. And in that
19 leadership role I had responsibility for leading
20 the work of my team, ensuring that we were meeting
21 our deadlines and overall ensuring the success of
22 that integrated R&D organization.

23 Q. Okay. But what do you mean by "work
24 stream"?

1 A. Work stream --

2 Q. I don't know what that means.

3 A. It's simply a way for us to describe a

4 subpiece of the overall project, which typically

5 has its own deliverables, its separate meetings

6 and separate partner oversight.

7 Q. What deliverables did you have?

8 A. Completing the Day 1 preparation for

9 the R&D team. Working with the R&D leadership to

10 design the new organization, in terms of boxes and

11 resources. And helping design the processes and

12 governance that would enable the new organization

13 to work.

14 Q. Can you explain to me in more detail

15 what completing the Day 1 preparation meant.

16 A. When two companies merge, on the first

17 day, when they are operational, there are a host

18 of small details that matter for the organization

19 to be functioning. For instance, bills need to be

20 paid, phones have to be answered, security cards

21 need to work.

22 That is also true for the R&D portions

23 of an organization. For example, if there were a

24 safety issue in a clinical trial, the agency needs

1 to be -- the Federal Drug Administration needs to
2 be notified who would be responsible for that.

3 And so there was a laundry list of
4 probably 100 or so items that had to be completed
5 on Day 1 to enable the company to meet its legal
6 obligations as well as be functioning on that
7 first day.

8 Q. Specifically, with respect to R&D, was
9 there anything in particular with respect to that,
10 other than what you have already described?

11 A. No.

12 Q. Okay. Then you also said helping
13 design processes and governance. Do I have that
14 right?

15 A. Yes.

16 Q. What did that involve?

17 A. What that involved is deciding how the
18 new integrated R&D organization was going to work:
19 Is there an executive committee that makes
20 decisions, how do they interact with each other.
21 There are a number of processes in R&D and how you
22 do things and which companies would be taken.

23 And although we couldn't complete all
24 that design, we at least wanted to start some of

1 that wiring so the combined leadership could

2 continue to decide, in essence, how the

3 organization was going to run globally.

4 Q. Would that include helping them

5 reorganize individuals in particular roles?

6 A. A little bit. But our emphasis was

7 less on fitting individuals into roles and more in

8 describing in the abstract how big the various

9 groups should be and where they should be located.

10 Q. And there was a third deliverable that

11 you mentioned, which I missed. But other than

12 completing the Day 1 preparation, helping design

13 processes and governance, and there was a third

14 that you mentioned. Do you recall what that was?

15 A. I will need help.

16 (WHEREUPON, the record was read

17 by the reporter.)

18 BY MS. TROAKE:

19 Q. I think that all related to the design

20 processes and governance.

21 But other than what you have already

22 described for me, what else would be one of the

23 deliverables that you would be concerned about?

24 A. I think we have covered them:

1 governance, processes, the organizational
2 structure, and probably also a softer one, which
3 is simply ensuring that the new leadership team is
4 working together somewhat constructively, which is
5 part of a merger as well.

6 Q. As part of all that work that McKinsey
7 was doing, would you attend regular meetings with
8 the senior management at Abbott?

9 MR. LORENZINI: Objection.

10 BY MS. TROAKE:

11 Q. You can answer.

12 A. Okay. Sorry. Thank you.

13 I would attend project team meetings
14 for the specific engagement.

15 Q. And what is a project team meeting?

16 A. It's a regularly scheduled update where
17 the McKinsey team meets with the leadership that
18 is responsible for the engagement and we talk
19 about how things are going and plan the next few
20 weeks.

21 Q. Is that just McKinsey people or does
22 that include Abbott people, or did that include
23 Abbott people?

24 A. It typically involves the McKinsey team

1 and the handful of Abbott people who are
2 overseeing the specific engagement.

3 Q. And with respect to the Abbott-Knoll
4 integration, how frequently would you have these
5 project team meetings?

6 A. I don't recall for this specific
7 engagement. Typically it's weekly or biweekly.

8 Q. And do you recall who from Abbott would
9 attend the project team meetings in this instance?

10 A. It would be Jeff Leiden, John Leonard,
11 and then a subset of more junior individuals who I
12 do not recall.

13 Q. Did Mr. Leiden and Mr. Leonard attend
14 each one of those project team meetings?

15 MR. LORENZINI: Objection.

16 BY THE WITNESS:

17 A. I don't recall.

18 BY MS. TROAKE:

19 Q. Do you recall whether they attended
20 most of those meetings?

21 MR. LORENZINI: Objection.

22 BY THE WITNESS:

23 A. Yes, they attended most of them.

24 BY MS. TROAKE:

1 portfolio and the compounds they were developing

2 in any of those discussions?

3 A. No.

4 Q. Anything else you can remember about

5 those one-on-one meetings with Dr. Leiden?

6 A. No.

7 Q. You also said you had some one-on-one

8 meetings with Joe Nemmers; is that right?

9 A. Yes.

10 Q. Do you recall how many of those you

11 had?

12 A. No. I would guess it was probably half

13 a dozen over the course of the engagement.

14 Q. In any of those one-on-one discussions

15 with Joe Nemmers, did you discuss in any way

16 Abbott's portfolio or the compounds that they were

17 developing?

18 A. No.

19 Q. You also mentioned that you attended

20 what you think was an off-site meeting in January

21 of '01 to kick off the merger; is that right?

22 A. Yes.

23 Q. And do you recall where that meeting

24 was?

1 A. At Abbott Park.

2 Q. And do you recall who attended that

3 meeting?

4 A. There were over 100 people there across

5 both the Abbott and Knoll organizations. It was

6 the formal kickoff.

7 Q. And how long did that meeting last?

8 A. Most of the day.

9 Q. Just one day or more than one day?

10 A. I don't recall.

11 Q. Was there an agenda circulated for that

12 kickoff meeting?

13 A. I don't recall.

14 Q. So there might have been, you just

15 don't remember?

16 A. Correct.

17 Q. Did you ever attend any meetings of the

18 R&D integration steering committee? Does that

19 ring any bells?

20 MR. LORENZINI: Objection.

21 BY THE WITNESS:

22 A. Yes.

23 BY MS. TROAKE:

24 Q. And do you recall what that committee

1 was?

2 A. I don't recall who exactly was on it,
3 but that was the governance structure we put into
4 place to regularly ensure that the R&D team was
5 working well together, and that would have been
6 the primary governance mechanism that we talked
7 about earlier in terms of meeting every week or
8 two to review progress.

9 Q. So that was the same -- that was the
10 entity that was meeting for these project team
11 meetings we already talked about?

12 A. Exactly.

13 Q. Okay. Did you or anyone else from
14 McKinsey ever meet with Abbott's board of
15 directors?

16 A. No.

17 Q. Other than the project team meetings
18 and the private one-on-ones and these off-site
19 meetings, the March and May ones I will get to in
20 a minute, did you have any regular communications
21 with employees at Abbott in relation to the
22 integration?

23 A. I did not, no.

24 Q. So the sole means for you to

1 communicate with the Abbott employees was through
2 the project team meetings and these other off-site
3 meetings?

4 A. Correct, and I would not myself be more
5 broadly communicating with the organization.

6 Q. What about anyone else on the McKinsey
7 team?

8 MR. LORENZINI: Objection.

9 BY THE WITNESS:

10 A. The only other communication that might
11 have taken place is not related to R&D but for the
12 overall integration. We had a communications team
13 that had responsibility for helping to script for
14 Abbott's corporate communication group some of the
15 general messages and announcements about the new
16 company, but those communications explicitly would
17 have come from Abbott and not from McKinsey. We
18 simply would have helped to develop them.

19 BY MS. TROAKE:

20 Q. What was the purpose in having McKinsey
21 present for the January kickoff meeting, do you
22 know?

23 MR. LORENZINI: Objection.

24 BY THE WITNESS:

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1 A. Since we had overall responsibility for
2 helping ensure the success of the integration
3 process, as part of that, we had a role in
4 designing that kickoff, facilitating portions of
5 it.

6 Richard Ashley gave one of the keynote
7 addresses, and we were asked to be there and help
8 to begin, in some sense, the cultural integration
9 of the two organizations.

10 BY MS. TROAKE:

11 Q. Did anyone else from McKinsey speak at
12 that kickoff?

13 A. I can't recall.

14 Q. Do you recall who from Abbott spoke at
15 that kickoff meeting?

16 A. I remember Joe Nemmers. I remember
17 there were others, but I cannot remember who they
18 were.

19 Q. Did anyone from McKinsey who attended
20 that kickoff meeting take notes during the course
21 of that meeting?

22 A. I don't know.

23 Q. Was anyone from McKinsey responsible
24 for documenting what was discussed at that kickoff

1 meeting and producing some kind of work product or
2 report or summary about that meeting?

3 MR. LORENZINI: Objection.

4 BY THE WITNESS:

5 A. I don't recall.

6 BY MS. TROAKE:

7 Q. Were you provided, you, meaning you
8 personally or anyone from McKinsey, provided with
9 documents from Abbott in preparation for this
10 consulting arrangement?

11 A. No.

12 Q. In the course of the consulting
13 arrangement, were you or anyone at McKinsey
14 provided with documents from Abbott about its
15 portfolio and its compounds?

16 A. Yes.

17 Q. What kinds of documents were you
18 provided? When I say "you," I mean you personally
19 and anyone at McKinsey.

20 A. I don't recall specifics of the
21 documents, but I do recall that we would have
22 received a number of materials such as
23 organization charts of the R&D sites, lists of the
24 R&D Abbott budgets, a description of the compounds

1 by pipeline phase, and in some cases, a few deeper
2 dives into a specific product, if that were
3 relevant to some site or personnel decision.

4 Q. What do you mean by "deeper dives"?

5 A. It would be a -- typically a 15- or
6 20-page document that would talk in more detail
7 about the compound, how it was being developed.

8 Q. Did you or anyone else at McKinsey
9 retain any of those documents once the Knoll
10 integration was completed?

11 A. I don't know for others. For myself, I
12 have provided everything that was retained.

13 Q. And, again, the people who were still
14 at McKinsey worked on this, you didn't check with
15 them as to whether they had any of these kinds of
16 documents?

17 A. They would not have had any specific
18 documents relating to R&D. Richard Ashley and
19 David Keeling were simply not materially involved
20 in that work stream.

21 Q. Do you recall receiving from Abbott any
22 documents like you have just described with
23 respect to ABT-518? Do you know what I am
24 referring to?

1 A. I know the compound you are referring
2 to. I don't recall.
3 Q. What about ABT-594?
4 A. I don't recall.
5 Q. And you know what I am referring to
6 when I say ABT-594?
7 A. Yes, I do.
8 Q. What about ABT-773?
9 A. I don't recall.
10 Q. You might have, you just don't
11 remember?
12 A. Correct.
13 Q. You don't appear to have kept any of
14 that material.
15 MR. LORENZINI: Objection.
16 BY THE WITNESS:
17 A. Correct.
18 BY MS. TROAKE:
19 Q. Was it part of McKinsey's role in its
20 arrangements with Abbott to make any
21 recommendations about how particular compounds
22 should be developed or whether a particular
23 compound should continue to be developed?
24 MR. LORENZINI: Objection, form.

1 BY THE WITNESS:

2 A. No.

3 BY MS. TROAKE:

4 Q. Was it part of McKinsey's role and
5 responsibilities to assist Abbott and, I guess, to
6 a certain degree, Knoll in terms of the
7 integration to assist them in deciding how to --
8 which compounds would be developed going forward?

9 MR. LORENZINI: Objection to form.

10 BY THE WITNESS:

11 A. Yes.

12 BY MS. TROAKE:

13 Q. And in terms of assisting them and
14 making those kinds of decisions, what precisely
15 would McKinsey do? What kind of work product or
16 deliverables would you provide?

17 MR. LORENZINI: Objection, vague.

18 BY THE WITNESS:

19 A. Our responsibility was to ensure that a
20 meeting was designed that had the relevant parties
21 in the room and that they were prepared to have an
22 overall conversation, so it was really to create
23 the conditions for them to have the conversations
24 they would like to have.

1 BY MS. TROAKE:

2 Q. And was that meeting the March 2001

3 off-site meeting that you referred to previously?

4 MR. LORENZINI: Objection.

5 BY THE WITNESS:

6 A. Yes.

7 BY MS. TROAKE:

8 Q. So, specifically with respect to that

9 off-site meeting, can you describe for me in more

10 detail your best recollection as to what McKinsey

11 did precisely?

12 MR. LORENZINI: Objection to form.

13 BY THE WITNESS:

14 A. My recollection is that I talked with

15 Joe Nemmers and Jeff Leiden beforehand to discuss

16 how to best design the several datas to ensure

17 that the groups had an effective interaction. I

18 helped design the agenda. And discussed with them

19 also what format the presentations should come in

20 since this was the first time that some of the

21 individuals had had a chance to present data to

22 Abbott. And so we wanted consistency across the

23 various presentations.

24 BY MS. TROAKE:

1 Q. Anything else?

2 A. No.

3 Q. Do you recall how much Abbott paid

4 McKinsey in relation to the consulting arrangement

5 for the Knoll integration?

6 A. Overall, it would have been between \$7

7 and \$10 million.

8 Q. Do you recall there being any dispute

9 with Abbott regarding payment for McKinsey's

10 services?

11 MR. HAKEMI: Objection, relevance.

12 BY THE WITNESS:

13 A. There was some back and forth about

14 capping the fees, which we agreed to.

15 BY MS. TROAKE:

16 Q. Do you recall when that dispute

17 occurred?

18 MR. LORENZINI: Objection.

19 BY THE WITNESS:

20 A. Spring of 2001, but I can't remember

21 more precisely.

22 BY MS. TROAKE:

23 Q. Do you recall when it was resolved?

24 A. No.

1 Q. Do you recall whether anyone at Abbott
2 ever complained about the work product or the
3 services being provided by McKinsey in the course
4 of this arrangement?

5 MR. LORENZINI: Objection.

6 BY THE WITNESS:

7 A. Yes.

8 BY MS. TROAKE:

9 Q. And what do you recall?

10 A. What I recall is some concern about the
11 overall process complexity and the number of
12 teams; in some sense, the overall scope of the
13 effort being quite burdensome.

14 Q. Anything else?

15 A. No.

16 Q. Do you recall anyone from Abbott ever
17 complaining that McKinsey's work product or the
18 deliverables, as you described it, were inaccurate
19 or incomplete in any way?

20 MR. LORENZINI: Objection.

21 BY THE WITNESS:

22 A. No.

23 BY MS. TROAKE:

24 Q. Do you have any recollection of

1 ABT-594 in the February or March of '01 timeframe?

2 MR. LORENZINI: Objection.

3 BY THE WITNESS:

4 A. No.

5 BY MS. TROAKE:

6 Q. Are you familiar at all with the

7 Phase IIB study related to ABT-594, referred to as

8 the M99-114 study?

9 A. I know it exists. I know none of the

10 details.

11 Q. How do you know it exists?

12 A. I recall it was what was discussed as

13 part of the portfolio review, but I don't recall

14 any of the characteristics of the study or the

15 outcomes.

16 Q. When you say it was discussed as part

17 of the portfolio review, are you referring to the

18 March of 2001 off-site meeting you spoke of

19 previously?

20 A. Yes.

21 Q. At that particular off-site meeting, do

22 you have a specific recollection about discussions

23 related to that study?

24 MR. LORENZINI: Objection.

1 BY THE WITNESS:

2 A. No.

3 BY MS. TROAKE:

4 Q. Do you have any recollection of any
5 discussions about the fact that the enrollment
6 with respect to that study had ended early?

7 MR. LORENZINI: Objection.

8 BY THE WITNESS:

9 A. I remember that statement. I do not
10 remember any further details.

11 BY MS. TROAKE:

12 Q. Do you remember who made that
13 statement?

14 A. No.

15 Q. Do you remember whether it was someone
16 from Abbott or someone from McKinsey?

17 A. It would be someone from Abbott.

18 Q. With respect to the same meeting
19 and the same compound, do you remember any
20 discussions around that particular study having
21 fewer subjects than it was originally designed
22 to have?

23 MR. LORENZINI: Objection.

24 BY THE WITNESS:

1 A. No.

2 BY MS. TROAKE:

3 Q. Other than a recollection about the

4 enrollment ending early with respect to that

5 study, do you recall any discussions about the

6 impact that that study would have on the

7 development of ABT-594 at that March of '01

8 meeting?

9 MR. LORENZINI: Objection to form.

10 BY THE WITNESS:

11 A. No.

12 BY MS. TROAKE:

13 Q. Do you have any recollection of any

14 discussions at any point in 2001 about ABT-594 and

15 adverse events such as nausea or vomiting?

16 MR. LORENZINI: Objection to form.

17 BY THE WITNESS:

18 A. The only discussion about ABT-594 that

19 I recall was that the compound was one of a dozen

20 or so that were discussed in a brief fashion at

21 the two off-sites. I don't recall any discussion

22 of nausea or vomiting.

23 BY MS. TROAKE:

24 Q. Do you recall any discussions in that

1 time period about ABT-594 in that particular study

2 and the need for the result of that study to be

3 unblinded?

4 MR. LORENZINI: Objection.

5 BY THE WITNESS:

6 A. I recall a discussion around needing to

7 understand Phase II in order to move to Phase III.

8 That's the extent of the recollection.

9 BY MS. TROAKE:

10 Q. Are you familiar with a group at Abbott

11 called the Decision Support Group?

12 A. Yes.

13 Q. Did you or anyone else from McKinsey

14 ever attend Decision Support Group meetings in

15 2001?

16 A. No.

17 MR. HAKEMI: When you get to a

18 convenient time, I need to take a quick

19 break if we could.

20 MS. TROAKE: Sure. Actually, we can take one

21 now. That would be fine.

22 THE VIDEOGRAPHER: Going off the video record

23 at 2:03 p.m.

24 (WHEREUPON, a recess was had.)

1 about what we had learned over the three days.

2 And the reason it's a hard question is because

3 some things were not known, some things were

4 known, but for us to agree on where we were.

5 BY MS. TROAKE:

6 Q. When you say "we," you mean Abbott?

7 MR. LORENZINI: Objection.

8 BY THE WITNESS:

9 A. I mean we as a group in charge of

10 knitting together the organization.

11 MS. TROAKE: This will be No. 4.

12 (WHEREUPON, a certain document

13 was marked Hopfield Deposition

14 Exhibit No. 4 for

15 identification, as of 6/18/07.)

16 BY MS. TROAKE:

17 Q. Ms. Hopfield, I put in front of you

18 what has been marked as Exhibit 4.

19 Do you recognize this document?

20 A. Yes.

21 Q. And what is it?

22 A. It is the -- they are the first few

23 slides that were shown to kick off or start up the

24 day of the portfolio review.

1 Q. Do you recall who prepared these
2 slides?

3 A. I did with my team.

4 Q. And were they shared with folks at
5 Abbott before the presentation?

6 MR. LORENZINI: Objection, lacks foundation.

7 BY THE WITNESS:

8 A. Yes.

9 BY MS. TROAKE:

10 Q. Do you recall who they were sent to at
11 Abbott prior to the presentation?

12 A. No.

13 Q. On the first page of Exhibit 4 in the
14 upper right-hand corner, there is -- on the very
15 first page --

16 A. I'm sorry.

17 Q. -- of Exhibit 4, upper right-hand
18 corner. That reference up there that begins with
19 "CH."

20 A. Yes.

21 Q. Do you know what that is?

22 A. Yes. That is a way that we have of
23 marking some of the documents that McKinsey
24 produces. That indicates it was based out of

1 presentation?

2 MR. LORENZINI: Objection.

3 BY THE WITNESS:

4 A. I don't remember.

5 BY MS. TROAKE:

6 Q. If you could turn to, in Exhibit 4, the
7 page that -- you see there are Bates numbers, what
8 I call Bates numbers, the MCK numbers.

9 A. Yes.

10 Q. If you turn to the one ending 382,
11 please. It says, "Decision-making approach going
12 forward."

13 A. Yes.

14 Q. And under the "What" category, it says,
15 "Classify products into three groups," and then it
16 lists three areas, the last one being "Projects
17 which will not be retained."

18 A. Yes.

19 Q. Do you recall what that reference
20 means, "Projects which will not be retained"?

21 MR. LORENZINI: Objection to form.

22 BY THE WITNESS:

23 A. Yes. This was specifically about the
24 Knoll portfolio. When Abbott purchased Knoll, in

1 addition to purchasing physical structure, they
2 purchased products, and the questions were which
3 of these projects should be retained in the new
4 legal entity and which should no longer be
5 continued.

6 BY MS. TROAKE:

7 Q. And category -- I'm sorry, does that --
8 are you describing this entire "What" to the
9 classified products into three groups, or are you
10 just saying the ones that would not be retained
11 were the Knoll ones -- ones in the Knoll
12 portfolio? I am confused.

13 A. Let me be more specific.

14 The driving force behind this off-site
15 was to see for the first time the Knoll portfolio
16 and assets. In order to do that fairly, we
17 actually discussed the integrated portfolio of
18 both companies, but the focus on our energy was on
19 Knoll.

20 We talked about whether we wanted to
21 retain those Knoll assets, and so that
22 classification of 1, 2 and 3, was really about do
23 we retain in the new entity the Knoll project or
24 asset, or in the point 3, which is not retained,

1 do we decide to do something else with that asset.

2 Q. Do you recall whether there was any

3 discussion of any of the Abbott compounds in

4 relation to any of the items under "Classify

5 products into three groups"?

6 MR. LORENZINI: Objection, vague and

7 ambiguous.

8 BY THE WITNESS:

9 A. We discussed that while we were

10 reviewing Knoll, it was also an opportunity to

11 look at Abbott, but that the primary focus were on

12 the Knoll assets that were new to the R&D

13 leadership group.

14 BY MS. TROAKE:

15 Q. I understand that was the primary

16 focus.

17 A. Yes.

18 Q. I guess my question was, do you recall

19 any discussion around the Abbott compounds with

20 regard to these three categories?

21 MR. LORENZINI: Objection to the form.

22 BY THE WITNESS:

23 A. No. You mean in terms -- no.

24 BY MS. TROAKE:

1 Q. Do you recall any discussions regarding
2 ABT-518 in relation to it being a project that
3 might not be retained at this off-site meeting in
4 March?

5 MR. LORENZINI: Objection to the form of the
6 question.

7 BY THE WITNESS:

8 A. I remember at the off-site, at the end
9 of the day, going through each compound of which
10 518 was one and having the leadership group
11 describe, based on the day, what they thought.

12 BY MS. TROAKE:

13 Q. And do you have a specific recollection
14 of what the leadership group thought about
15 ABT-518?

16 MR. LORENZINI: Objection to the form.

17 BY THE WITNESS:

18 A. No.

19 BY MS. TROAKE:

20 Q. What about with respect to ABT-594, do
21 you have any recollection with respect to that
22 compound and any discussions in relation to it
23 being a project that might not be retained as
24 described in this slide?

1 MR. LORENZINI: Objection to form.

2 BY THE WITNESS:

3 A. I recall that there was some concern

4 about the Phase II data, and, therefore, it

5 warranted further discussion.

6 BY MS. TROAKE:

7 Q. Can you recall any more specifically

8 what the concerns were about the Phase II data?

9 MR. LORENZINI: Objection to the form of the

10 question.

11 BY THE WITNESS:

12 A. No.

13 BY MS. TROAKE:

14 Q. But you recall those concerns about the

15 Phase II data being discussed during this March

16 off-site?

17 A. Yes.

18 Q. Under the -- when on this page, it

19 says, "Initial list of projects in the third group

20 will be communicated within 1-2 weeks."

21 Do you see that?

22 A. Yes.

23 Q. Do you recall whether ABT-518 or

24 ABT-594 were within that third group --

1 A. No.

2 Q. -- that were going to be communicated

3 within one to two weeks?

4 A. No, I do not.

5 Q. You don't recall either way, or you

6 don't recall that they weren't included?

7 MR. LORENZINI: Objection.

8 MS. TROAKE: Let me strike that and start

9 again.

10 BY MS. TROAKE:

11 Q. Do you have any recollection of ABT-518

12 or ABT-594 being included in that list of projects

13 that is referenced under the first bullet point

14 next to "When"?

15 MR. LORENZINI: Objection.

16 BY THE WITNESS:

17 A. No, I do not recall them being part of

18 that list.

19 BY MS. TROAKE:

20 Q. So they could have been, but you just

21 don't recall?

22 MR. LORENZINI: Objection.

23 BY THE WITNESS:

24 A. Correct.

1 BY MS. TROAKE:

2 Q. Also under the "When," the second

3 bullet point says, "All other projects to continue

4 as planned until final prioritization completed by

5 early May."

6 Do you recall what that references?

7 A. Yes. That reference was specifically

8 related to the Knoll assets, which was that

9 if -- unless something met that first, it will not

10 be retained. So a Knoll asset that explicitly

11 Abbott had no interest in, that all other

12 development and pipeline products of Knoll should

13 continue until they got the word in May as to

14 their role in the portfolio.

15 Q. And what was happening in May?

16 A. That simply enabled more time for the

17 combined leadership to look at the clinical data

18 and make a decision. It usually requires quite a

19 lot of review.

20 Q. Was there any particular event

21 happening in May that you recall was a reason for

22 having it completed by early May?

23 A. It was simply a balance of needing time

24 but trying to keep moving forward.

1 Q. If you look at the last three pages of

2 that exhibit.

3 A. Yes.

4 Q. Exhibit 4. There's three agendas. One

5 for Wednesday, March 7; Thursday, March 8; and

6 Friday, March 9.

7 A. Yes.

8 Q. And were these the agendas, as far as

9 you can recall, that were used for the off-site in

10 March of 2001 that we have been talking about?

11 A. Yes.

12 Q. And was someone from McKinsey present

13 for each of these meetings that are on the agendas

14 on these three pages?

15 MR. LORENZINI: Objection.

16 BY THE WITNESS:

17 A. I recall I was there for at least two

18 of the days. I believe someone from my team was

19 there for all three.

20 BY MS. TROAKE:

21 Q. And was one of the purposes of either

22 you or someone else from McKinsey being there on

23 those three days to document the discussion and

24 any decisions made in the course of that

1 discussion?

2 MR. LORENZINI: Objection to the form of the

3 question.

4 BY THE WITNESS:

5 A. No.

6 BY MS. TROAKE:

7 Q. What was the purpose --

8 A. The purpose -- sorry.

9 Q. -- of either you or someone else from

10 McKinsey attending those meetings?

11 MR. LORENZINI: Objection.

12 BY THE WITNESS:

13 A. To have a chance to learn about the

14 portfolio and to see the senior leadership of

15 Knoll present.

16 BY MS. TROAKE:

17 Q. Why would you want to see the senior

18 leadership of Knoll present?

19 A. Because this was the first time that

20 the Knoll leadership was visible and working with

21 Abbott. And since our responsibility was to help

22 Abbott design a combined R&D organization, it was

23 important for us to get to know the senior Knoll

24 executives.

1 (WHEREUPON, a certain document
2 was marked Hopfield Deposition
3 Exhibit No. 5 for
4 identification, as of 6/18/07.)

5 BY MS. TROAKE:

6 Q. Ms. Hopfield, I put in front of you
7 what has been marked as Exhibit 5.

8 Would you take a look at that, please,
9 and let me know whether you recognize that
10 document.

11 A. Yes, I recognize it.

12 Q. And what is it?

13 MR. LORENZINI: Objection to the form.

14 BY THE WITNESS:

15 A. They are the overall summary of the
16 smaller group sessions that happened as part of
17 the off-site. And the discussion by the -- the
18 summary of the discussion that the group had by
19 product.

20 BY MS. TROAKE:

21 Q. And do you recall who is responsible
22 for putting together this summary, as you have
23 described it?

24 A. Yes. It was put together by Michael

1 Williams.

2 Q. And so does that refresh your

3 recollection at all as to who else from McKinsey

4 was attending the March off-site?

5 A. Michael Williams would have been there

6 for at least part of it. I don't recall if he was

7 there for all of it. Between the two of us,

8 someone was there the whole time.

9 Q. So would the summary, which I take it

10 is the attached document, the document attached to

11 the e-mail, would that have been a collaboration

12 between you and Mr. Williams?

13 A. That's correct.

14 Q. And how did you do that? Did you take

15 notes in the course of the presentations over the

16 three days?

17 MR. LORENZINI: Objection.

18 BY THE WITNESS:

19 A. This is not a summary of the

20 presentations. This is a summary of the sessions

21 that happen outside of these large plenary groups,

22 when the Abbott leadership as a smaller group was

23 meeting.

24 BY MS. TROAKE:

1 Q. So the executive sessions we saw in the
2 prior document?

3 A. Correct. Right. And there, our
4 working norms would have been that Michael and I
5 would each take notes, and then we would have
6 compared notes and together have written this
7 document in the evenings.

8 Q. When you were taking notes, you and
9 Mr. Williams at those executive sessions, did you
10 take them by hand or did you have a laptop
11 computer you were using?

12 A. We took them by hand.

13 Q. What did you do with the notes after
14 you discussed them and combined them into this
15 document?

16 A. I don't know.

17 Q. In looking at the covering e-mail, in
18 Exhibit 5 -- actually, there are two e-mails. One
19 you forwarded to Patricia Weber at the top.

20 Do you see that?

21 A. Yes.

22 Q. Where it says in the subject line,
23 "Please print and put in mail folder."

24 A. Yes.

1 Q. Do you recall what that means?

2 A. It means I wanted her to print out the
3 attached e-mail and put it in the folder on her
4 desk where I picked up documents from her.

5 Q. So that is not an electronic mail
6 folder?

7 A. No, no. She had access to a printer
8 and could therefore print.

9 Q. And then the e-mail from Mr. Williams
10 to Mr. Leiden, which is dated March 13, 2001,
11 which you are copied on.

12 Do you see that?

13 A. Yes.

14 Q. The subject line to that says, "List of
15 next steps from portfolio review."

16 A. Yes.

17 Q. And that list of next steps and
18 portfolio review, do you recall that is referring
19 to the attached document which is initialed
20 "portfolio prioritization"?

21 A. Yes, it is.

22 Q. And then in Mr. Williams' e-mail to
23 Dr. Leiden, the third sentence says, "You may wish
24 to make changes to the list before it is more

1 broadly distributed and we can make edits based on
2 your handwritten comments if necessary."

3 Do you see that?

4 A. Yes.

5 Q. My first question about that sentence
6 is the reference to "before it is more broadly
7 distributed."

8 Do you recall whether this document,
9 initial portfolio prioritization, was more broadly
10 distributed than indicated in this e-mail?

11 MR. LORENZINI: Objection, calls for
12 speculation; lacks foundation.

13 MS. TROAKE: I am just asking if she knows.

14 MR. LORENZINI: I am just objecting.

15 BY THE WITNESS:

16 A. I don't know for this specific
17 document. I mean, I can infer. I mean, our
18 working norm was to have somebody closest to it
19 review it and then it would go out to the broader
20 R&D team.

21 BY MS. TROAKE:

22 Q. But you don't have a specific
23 recollection whether this document, initial
24 portfolio prioritization, was more broadly

1 circulated?

2 A. I don't recall.

3 Q. The second part of that says, "we can

4 make edits based on your handwritten comments if

5 necessary."

6 Do you see that?

7 A. Yes.

8 Q. Do you have any recollection of

9 receiving any comments, handwritten or otherwise,

10 from Dr. Leiden at this time?

11 A. I don't recall receiving any

12 handwritten comments. I don't know if he sent any

13 comments electronically or via voice. I don't

14 know.

15 Q. Do you have any recollection of making

16 any changes to this document after March 13, 2001?

17 MR. LORENZINI: Objection.

18 BY THE WITNESS:

19 A. I don't recall.

20 BY MS. TROAKE:

21 Q. The last sentence in the e-mail says,

22 "We are also in the process of compiling the

23 comments and results from the evaluation forms

24 which we'll forward to you by later this week."

1 Q. And, again, you don't recall what
2 happened to Mr. Williams' e-mails after he left
3 McKinsey?

4 A. No.

5 Q. If you look at the attachment, please,
6 the initial portfolio prioritization, it is
7 actually the one Bates-labeled 425, that page. It
8 has oncology as the first project group.

9 A. Yes.

10 Q. Do you see that?

11 There is a reference here to ABT-518.

12 Do you see that?

13 A. Yes.

14 Q. Under "Priority," it says, "Hold."

15 Do you have any recollection of what
16 that refers to, the word "hold"?

17 MR. LORENZINI: Objection.

18 BY THE WITNESS:

19 A. Yes. This was a case where we wanted
20 to understand the Phase II results and we could
21 not yet make a decision about what to do, and so
22 our assessment of it was put on hold until we knew
23 more.

24 BY MS. TROAKE:

1 Q. The Phase II results -- I don't mean to
2 confuse you, but I know we were talking about a
3 Phase IIB study with respect to ABT-594
4 previously.

5 Is that what you were referencing?

6 A. Oh, I'm sorry. No, it would have been
7 another clinical result. I'm sorry. I was
8 getting ABT numbers confused.

9 Q. Okay.

10 A. There would have been other clinical
11 information, and I don't recall what we were
12 waiting for.

13 Q. Do you recall whether there was any
14 discussion about waiting for information that
15 might be provided at a conference referred to as
16 ASCO?

17 A. No.

18 Q. Do you know what ASCO is?

19 A. Yes.

20 Q. What is it?

21 A. It's the American Society of Clinical
22 Oncologists and is the leading information
23 exchange in the US every year for clinical trial
24 results.

1 Q. And presumably if that had been one of
2 the things that was effecting the reference to
3 hold, it would have been indicated under the next
4 steps for 518?

5 MR. LORENZINI: Objection, mischaracterizes
6 the document.

7 BY THE WITNESS:

8 A. Not necessarily. The next steps was
9 not a listing of all the details. It was simply
10 saying wait for May.

11 BY MS. TROAKE:

12 Q. Well --

13 A. Results in May.

14 Q. Well, under "Next steps," it does say,
15 "Wait for May results from Pfizer." Right?

16 A. Yes.

17 Q. So if Abbott was waiting for the
18 results or the information to be provided at the
19 ASCO conference and that was discussed at the
20 executive session, it probably would have been
21 listed under "Next steps," wouldn't it?

22 MR. LORENZINI: Objection, mischaracterizes
23 the document.

24 BY THE WITNESS:

1 A. No.

2 BY MS. TROAKE:

3 Q. Why not?

4 A. In writing the next steps, it's a
5 paraphrase of a discussion. So had it been ASCO,
6 would it specifically have been called out, no.
7 May results might be referring to ASCO, it might
8 be referring to something else.

9 Q. You don't have any specific
10 recollection of ASCO being mentioned?

11 A. No.

12 Q. Do you recall any discussions with
13 anyone from Abbott about the reference to hold
14 next to ABT-518 after this e-mail was sent on
15 March 13, 2001?

16 MR. LORENZINI: Objection.

17 BY THE WITNESS:

18 A. No.

19 BY MS. TROAKE:

20 Q. Under "Next steps," it also says next
21 to ABT-518, "Halt all further expenditure."

22 Do you see that?

23 A. Yes.

24 Q. Do you have any recollection of what

1 that is referring to?

2 MR. LORENZINI: Objection.

3 BY THE WITNESS:

4 A. Yes. That was the idea that any

5 optional clinical or commercial spend should be

6 stopped until it was clear what was going to

7 happen to the compound.

8 BY MS. TROAKE:

9 Q. If you could turn two pages, the Bates

10 number is 427. At the top it says,

11 "Neuroscience," and just below that is "ABT-594."

12 Do you see that?

13 A. Yes.

14 Q. Under "Priority," that says, "P." And

15 you will note in the upper right-hand corner, P

16 indicates pending. Right?

17 A. Yes.

18 Q. Do you have any recollection of what

19 the difference between "pending" is as referenced

20 under 594 and the "hold" we saw next to 518?

21 A. Yes.

22 Q. And what is the difference?

23 A. "Pending" is when there were ongoing

24 trials and clinical spend and we simply did not

1 know enough to make a decision. So the program
2 was to continue as planned by the team. And
3 pending we would make more decisions when we knew
4 more.

5 "Hold" meant do not spend any
6 incremental funds if not required until a decision
7 was made.

8 Q. Also, under "Next steps" for ABT-594,
9 there it says, "Await results from ongoing PII
10 trial."

11 Do you recall if that was reference to
12 the Phase IIB trial we were talking about?

13 A. Yes.

14 Q. Then it says, "Probable T." And if we
15 look in the upper right-hand corner, "T" means
16 terminate, correct?

17 A. Yes.

18 Q. Do you have any recollection about what
19 the reference to "probable T" meant?

20 MR. LORENZINI: Objection to the form of the
21 question.

22 BY THE WITNESS:

23 A. Yes. It was the collective judgment of
24 the smaller group discussing this that the

1 likelihood was that the Phase II results would

2 indicate it should be terminated.

3 BY MS. TROAKE:

4 Q. And when you said the smaller group,

5 that's the executive session we were talking about

6 previously, and I think Dr. Leiden was present for

7 those?

8 A. Yes.

9 Q. And -- I'm sorry, you said the results

10 of the Phase IIB trial, those results would likely

11 cause them to terminate 594. Is that right; is

12 that what you said?

13 MR. LORENZINI: Objection.

14 MS. TROAKE: I am just trying to clarify her

15 prior answer.

16 MR. LORENZINI: I am just trying to object.

17 MS. TROAKE: I can see that.

18 BY THE WITNESS:

19 A. The group was guessing as clinicians

20 what they thought the likely outcome of the trial

21 would be and the likely outcome of the program.

22 And their guess was it would be negative, so they

23 would terminate.

24 BY MS. TROAKE:

1 Q. Do you know what that guess, as you

2 have described it, was based on?

3 MR. LORENZINI: Objection, calls for

4 speculation.

5 BY THE WITNESS:

6 A. Decades of clinical development

7 experience and having seen more of the clinical

8 program.

9 BY MS. TROAKE:

10 Q. More of which clinical program?

11 A. Of the 594 preclinical Phase I,

12 et cetera. It's an Abbott compound, so they would

13 be aware of rather more of the data and therefore

14 they would have a viewpoint about the likelihood

15 of the trial being successful.

16 Q. And do you recall any specific

17 discussions, any more detail about what their

18 thoughts were about that trial?

19 A. No.

20 Q. Do you recall any discussions during

21 any one of the executive sessions over those three

22 days that we were talking about previously, where

23 Dr. Leiden indicated that he was halting the

24 development of 518, ABT-518?

1 MR. LORENZINI: Objection.

2 BY THE WITNESS:

3 A. I don't recall.

4 MS. TROAKE: This will be Exhibit 6.

5 (WHEREUPON, a certain document

6 was marked Hopfield Deposition

7 Exhibit No. 6 for

8 identification, as of 6/18/07.)

9 BY MS. TROAKE:

10 Q. Ms. Hopfield, I put in front of you

11 what has been marked as Exhibit 6.

12 Do you recognize that document?

13 A. Yes.

14 Q. And what is it?

15 A. It is another version of the initial

16 portfolio prioritization.

17 Q. And do you know, or can you tell from

18 looking at Exhibit 6, whether it's a later version

19 of the initial portfolio prioritization from the

20 one that we saw attached in Exhibit 5?

21 A. I can't tell for sure.

22 Q. If you look at the second page of

23 Exhibit 6, there is a reference again under

24 "Oncology" to ABT-518.

1 Do you see that?

2 A. Yes.

3 Q. Unlike the initial portfolio

4 prioritization we saw previously, under

5 "Priority," it now says, "hold/T."

6 And I think as in the past version, the

7 upper right-hand corner says T means terminate,

8 right?

9 A. Yes.

10 Q. Do you have any recollection with

11 respect to this version of the initial portfolio

12 prioritization as to what the "hold/T" under

13 "Priority" meant?

14 MR. LORENZINI: Objection.

15 BY THE WITNESS:

16 A. No, I don't recall how hold was turned

17 into a hold/T.

18 BY MS. TROAKE:

19 Q. Do you have any recollection of

20 discussions with anybody, either Michael Williams

21 or anyone at Abbott, as to why that was changed

22 from hold to hold/T?

23 A. No.

24 Q. With respect to the initial portfolio

1 prioritization, the one we saw in Exhibit 5 and
2 this one, Exhibit 6, did McKinsey prepare this
3 document in part to assist Abbott in its decisions
4 about what to do with the portfolio?

5 MR. LORENZINI: Objection.

6 BY THE WITNESS:

7 A. We prepared it to document where the
8 group landed in the discussions and to give them
9 some documentation as they moved forward as a
10 team.

11 BY MS. TROAKE:

12 Q. But the purpose of giving them that
13 documentation, was it in part to assist them in
14 the process that they were going through?

15 A. Yes.

16 Q. Do you have any recollection of any
17 discussions in the course of the March portfolio
18 review, that was off site, of any discussions
19 about Abbott stopping development of 518?

20 MR. LORENZINI: Objection.

21 BY THE WITNESS:

22 A. No.

23 BY MS. TROAKE:

24 Q. Do you have any recollection of

1 learning after the March portfolio review that
2 Abbott had in some way restarted or -- strike
3 that.

4 Do you have any recollection of
5 learning after the March portfolio review that
6 Abbott restarted development of ABT-518?

7 MR. LORENZINI: Objection.

8 BY THE WITNESS:

9 A. No, no recollection.

10 BY MS. TROAKE:

11 Q. On the initial portfolio
12 prioritization, both the one in Exhibit 5 and the
13 one in Exhibit 6, they both indicate for 518, halt
14 all expenditures.

15 A. Yes.

16 Q. "Halt all further expenditures," excuse
17 me.

18 Do you recall learning at any point
19 after March of '01 that next steps, as is
20 described in these documents, was changed in some
21 way?

22 A. I did not know that.

23 Q. But you don't recall hearing that?

24 A. No.

1 (WHEREUPON, a certain document

2 was marked Hopfield Deposition

3 Exhibit No. 7 for

4 identification, as of 6/18/07.)

5 BY MS. TROAKE:

6 Q. Ms. Hopfield, we put in front of you

7 what has been marked Exhibit 7.

8 If you could take a moment to look at

9 that document, please, and let me know whether you

10 recognize it.

11 A. Yes.

12 Q. And what is it?

13 A. It is a progress review document to

14 update the integration leadership on where we were

15 with the R&D work stream.

16 Q. I'm sorry, you said it's a progress

17 review document; is that what you said?

18 A. Yes.

19 Q. And it was used to?

20 A. Update the integration leadership about

21 where we stood in terms of the R&D work stream.

22 Q. And it was created by McKinsey; is that

23 right?

24 A. Yes.

1 Q. And it was created by McKinsey like the
2 initial portfolio prioritizations in the course of
3 your work for Abbott during this time period,
4 2001?

5 A. Yes.

6 Q. Was this provided to Abbott in some
7 form?

8 A. Yes. This would have typically been
9 handed out in paper copy at the meeting.

10 Q. And you said "at the meeting." Was
11 that a meeting on March 19, the date that is
12 indicated on the first page of Exhibit 7?

13 A. I think so.

14 Q. Do you recall who attended that
15 meeting?

16 A. No.

17 Q. Was Dr. Leiden at that meeting?

18 A. It would have been typical for him, but
19 I don't recall specifically who was at this
20 session.

21 Q. Do you recall whether it was the same
22 group who attended the executive sessions at the
23 earlier March portfolio review?

24 MR. LORENZINI: Objection.

1 BY THE WITNESS:

2 A. I don't have any recollection of the
3 participants at this specific meeting. Typically
4 this would be some of those people, but not all.

5 BY MS. TROAKE:

6 Q. Do you recall who from McKinsey
7 attended?

8 A. No.

9 Q. Looking at the second page of Exhibit
10 7. The first bullet is "Update on the development
11 portfolio review." And on the next page, there is
12 a timeline to finalize the pharma R&D program.

13 Do you see that?

14 A. Yes.

15 Q. There is a list of individuals on the
16 right under the "Responsibility" column: John
17 Leonard, Bob Funck, Dan Norbeck, Keith Hendricks,
18 and pharma executive management committee.

19 Do you see that?

20 A. Yes.

21 Q. Does that refresh your recollection at
22 all as to whether any of those individuals or
23 members of that committee were present at the
24 March 19 meeting?

1 A. I can't specifically recall the March
2 19 meeting. However, that would be the set of
3 individuals who would be at the steering
4 committee. They have the right responsibilities
5 to have been there.

6 Q. Do you recall who was on the pharma
7 executive management committee that is referenced
8 under "Responsibility"?

9 A. I recall a subset. I probably will not
10 get the composition correct. But it did
11 include -- it did include Ed Ogunro, Eugene Sunn,
12 John Leonard and Jeff Leiden.

13 Q. And on this timeline, the last item
14 under the "Review" column says, "Final pharma R&D
15 program"; under "Date," it says, "May 8"; and
16 "Responsibility," "Pharma executive management
17 committee."

18 Do you see that?

19 A. Yes.

20 Q. Do you recall what that referred to?

21 A. Yes. That was a deadline for
22 presenting an integrated R&D program across the
23 two companies, with the overall portfolio and
24 budget.

Hopfield, Jessica (Linked) 6/18/2007 1:01:00 PM

1 I need to amend an earlier answer.

2 Q. Okay.

3 A. The pharma executive management

4 committee, now that I look at this, is probably

5 not the R&D committee but, in fact, is the

6 business executive management committee. You had

7 asked me who was on that committee and so I gave

8 the wrong names of individuals.

9 Q. Okay. Which ones were wrong?

10 A. It would include Jeff Leiden. It would

11 not have Ed Ogunro and Eugene Sunn.

12 Q. Okay.

13 A. These would be business leaders.

14 Q. Coming back to the May 8 date, you said

15 that would be a deadline for presenting the final

16 R&D program with the overall portfolio and budget;

17 is that right?

18 A. Yes.

19 Q. And that would be the overall portfolio

20 for both Abbott and Knoll as one entity?

21 A. Yes.

22 Q. If you look at the next page of

23 Exhibit 7, again, we have the initial portfolio

24 prioritization that we have seen in Exhibit 5 and

1 THE WITNESS: Sure.

2 MS. TROAKE: For a couple minutes.

3 THE VIDEOGRAPHER: Going off the video record

4 at 3:14 p.m.

5 (WHEREUPON, a recess was had.)

6 (WHEREUPON, certain documents

7 were marked Hopfield Deposition

8 Exhibit Nos. 8 through 11 for

9 identification, as of 6/18/07.)

10 THE VIDEOGRAPHER: Going back on the video

11 record at 3:30 p.m., the beginning of tape No. 3.

12 BY MS. TROAKE:

13 Q. Ms. Hopfield, I put in front of you

14 what has been marked as Exhibit 8.

15 Take a look at that, please, and let me

16 know whether you recognize that document.

17 A. Yes, I do recognize it.

18 Q. And what is it?

19 A. It's a fact pack, which Doane Chilcoat

20 produced, a member of my team, to help orient the

21 McKinsey team to the sort of practical details of

22 the R&D organization, so it was an internal

23 McKinsey reference document.

24 Q. So do you recall whether this

1 particular document, Exhibit 8, was ever

2 circulated to anyone at Abbott?

3 A. I don't recall if it was shared with

4 anyone. As a matter of practice, though, we would

5 not broadly circulate a fact pack.

6 Q. And is a "fact pack" a term used at

7 McKinsey?

8 A. Yes, it is.

9 Q. And what does it mean?

10 A. It is a basic overview of fundamental

11 details that a team needs to accomplish an

12 engagement and it is just that: It is facts as

13 opposed to synthesis or ideas or detailed

14 analytics, it's just the basic details.

15 Q. And is one of the goals to be as

16 complete and accurate as possible in the fact pack

17 so people can complete the engagement, as you

18 described it?

19 MR. LORENZINI: Objection.

20 BY THE WITNESS:

21 A. The goal is to be fairly complete and

22 fairly accurate. It's not to necessarily have

23 this be complete. It's what we have pulled

24 together, and so it will vary in its detail and

1 its accuracy. But it's the best we have.

2 BY MS. TROAKE:

3 Q. So at any given point in time, for

4 example, this one being dated April of 2001, it's

5 as complete and accurate as it could be as of

6 April of 2001?

7 MR. LORENZINI: Objection.

8 MR. HAKEMI: Objection to form.

9 BY THE WITNESS:

10 A. It's what Doane Chilcoat had available

11 in April of 2001. I doubt it is either complete

12 or accurate. It's what he could assemble for the

13 team's use.

14 BY MS. TROAKE:

15 Q. And it's what he could assemble from

16 what sources, if you know?

17 A. From Abbott documents and materials

18 that were shared with us.

19 Q. So to the extent it's a summary of the

20 Abbott materials and documents shared with

21 McKinsey, would you not try and be as accurate as

22 possible in summarizing that information in those

23 documents in the fact pack?

24 MR. LORENZINI: Objection, asked and

1 because this was in flux, there was a plan, there
2 was a budget put together. The budget was simply
3 the sum of what we knew existed. That was
4 different than the committed budget for the rest
5 of the year. It was simply doing the math, in
6 some sense. There was not a thoughtful
7 distinction between those two concepts. This was
8 all going to be worked out post May.

9 BY MS. TROAKE:

10 Q. Do you recall any discussions with
11 anyone at Abbott about their expected spending
12 versus budget or target as we have seen in these
13 two documents?

14 MR. LORENZINI: Objection, vague, ambiguous.

15 BY THE WITNESS:

16 A. I remember discussion overall about the
17 numbers and, in some sense, the envelope and
18 amount of spend, but not of individual assets.

19 BY MS. TROAKE:

20 Q. What about the -- do you have any
21 recollection of the term "nominal" versus
22 "expected" spending being used in discussions with
23 Abbott?

24 A. No.

1 Q. Do you have any understanding, as you
2 sit here today, about the distinction between
3 nominal versus expected spending as it relates to
4 Abbott?

5 A. Yes.

6 Q. And what is your understanding?

7 MR. LORENZINI: Objection.

8 BY THE WITNESS:

9 A. My understanding is that the Abbott R&D
10 budgeting process has multiple puts and takes in
11 it. And there will be a pro forma budget that is
12 developed for the year, but then the spending has
13 its lumpiness, which is then tracked. And these
14 things are updated and there are several different
15 ways of describing those puts and takes to the
16 budget over time.

17 BY MS. TROAKE:

18 Q. And how, specifically, does that form
19 the distinction between nominal versus expected?
20 I don't see the link between what you just
21 described and nominal versus expected, which is
22 what my question related to.

23 A. I have heard those used as ways to
24 describe the difference between the actual run

1 rate versus what they budgeted for the year.

2 Q. And what do you understand to be the

3 actual run rate, nominal or expected?

4 MR. LORENZINI: Objection, lacks foundation;

5 calls for speculation.

6 BY THE WITNESS:

7 A. Nominal.

8 BY MS. TROAKE:

9 Q. What is the basis for your

10 understanding?

11 A. Support that I provided to Abbott in

12 2002, 2003 on some R&D organizational issues.

13 Q. And what did that support relate to?

14 A. Specifically designing some

15 organizational structures to enable

16 decision-making of the combined R&D organization.

17 Q. Can you be more specific?

18 A. About a year after they had formed the

19 company, it was clear they did not have a way for

20 the top 15 or 20 R&D executives to work together

21 and make decisions, and they had not yet decided

22 how to divide up into subgroups. So I provided

23 support to John Leonard and some of his colleagues

24 to think about how the group should be organized.

1 Q. And how did the issues of nominal
2 versus expected spending fit into that support?

3 MR. LORENZINI: I am just going to object to,
4 I think, this whole line of questioning on nominal
5 versus expected. There is some vagueness and
6 ambiguity in the questions, so I object to the
7 form.

8 BY THE WITNESS:

9 A. Although that work was entirely
10 organizational, as part of that, I would have seen
11 some budgets, some plans, and there were those
12 terms in those budgets and plans.

13 BY MS. TROAKE:

14 Q. Do you recall seeing similar budgets
15 and plans using those terms, nominal and expected,
16 in the course of your work in 2001 in relation to
17 the Knoll integration?

18 MR. LORENZINI: Objection.

19 BY THE WITNESS:

20 A. No.

21 BY MS. TROAKE:

22 Q. If you could turn to the page
23 Bates-labeled 308 in Exhibit 8, please.

24 A. Yes.

1 various years?

2 A. Yes.

3 Q. 2000, 2001, going through to 2005. And

4 it says, "Cost to NDA."

5 Do you see that?

6 A. Yes.

7 Q. Under 2001, can you tell me what the

8 total is for that on Exhibit 12.

9 A. 15.

10 Q. Okay. And that development template,

11 Exhibit 12, what compound is that for?

12 A. ABT-594.

13 Q. Do you have any recollection as to why

14 there is a difference between that development

15 template and what is listed in the fact pack,

16 McKinsey fact pack?

17 A. No.

18 Q. Do you have any recollection of any

19 discussions with anybody at Abbott as to why that

20 development review template would say 15 million

21 for 2001, and yet this says 9.3 million, what the

22 difference was?

23 A. No.

24 Q. If you could turn to page 311 in

1 Exhibit 8, please.

2 A. Yes.

3 Q. It's "Potential savings from
4 terminating development projects" at the top.

5 A. Yes.

6 Q. And over on the right, under the word
7 "Projects," it says, "Preliminary."

8 A. Yes.

9 Q. Do you recall what that refers to?

10 A. Yes. This was not a final client
11 recommendation. This was a thought exercise of if
12 we were to stop doing a number of projects, how
13 much money would that save to help us just
14 understand what some opportunities might be.

15 Q. And do you recall how you came up with
16 this list on this page?

17 A. Yes. We took all products that we
18 believed would be terminated from discussions with
19 the client, and products that either had some
20 challenging discussions or, you know, had some
21 reason to believe -- some reason to terminate it,
22 and it really was a thought exercise.

23 Q. Okay. The first four program names --

24 A. Yes.

1 Q. -- say, "Priority," "terminate,"
2 "terminate," "terminate." Right? As best you can
3 recall, those are the products you believe, based
4 on your discussions with the client, would be
5 terminated?

6 MR. LORENZINI: Objection, mischaracterizes
7 the document.

8 BY THE WITNESS:

9 A. That priority listing was based on the
10 outcome of the off-site. That does not mean a
11 decision had been made to terminate them. It's
12 that in the off-site that the discussion had been
13 they could be terminated.

14 BY MS. TROAKE:

15 Q. When you say that they could be
16 terminated, what do you mean?

17 MR. LORENZINI: Objection.

18 BY THE WITNESS:

19 A. The off-site discussion about
20 termination was not a decision to terminate. It
21 was a discussion of the leadership group that that
22 was a likely thing to do with the compound. I
23 make that distinction because, in clinical
24 research, the decision to actually terminate,

1 which means no more patient receives drugs, is a
2 very complicated and very lengthy decision.

3 So the fact that the group had met off
4 site and said terminate does not mean that the
5 project had yet, in fact, been terminated.

6 MS. TROAKE: Could you read that answer back,
7 please.

8 (WHEREUPON, the record was read
9 by the reporter.)

10 BY MS. TROAKE:

11 Q. So I just want to flush that out, if I
12 might.

13 So "terminate" in your view relates to
14 whether patients will get that -- continue to get
15 that drug? Do I understand that?

16 MR. LORENZINI: Objection.

17 BY THE WITNESS:

18 A. Terminate to me means whether or not
19 you continue to incrementally put new patients on
20 the drug or whether you continue to incrementally
21 advance the compound through trials. It can mean
22 either one of those.

23 BY MS. TROAKE:

24 Q. And in your experience, if you decide

1 not to incrementally -- I'm sorry, I can't

2 remember the phrase you used.

3 A. Yeah, yeah.

4 Q. If you decide not to continue to give
5 patients the drug, I will use that as shorthand.

6 A. Yeah.

7 Q. That's a complicated decision?

8 A. Yes.

9 Q. Okay. And so if a pharmaceutical
10 company decided to stop or, better yet, decided
11 not to dose patients and halt a particular trial,
12 in your experience, would that decision likely be
13 reversed?

14 MR. LORENZINI: Objection, incomplete
15 hypothetical.

16 MS. TROAKE: I'm not finished.

17 MR. LORENZINI: Okay.

18 BY MS. TROAKE:

19 Q. Likely be reversed within 24 hours of
20 indicating to the people running the trial that
21 they want it terminated and stopped?

22 MR. LORENZINI: Objection, lacks foundation.

23 MR. HAKEMI: And to the form of the question.

24 BY THE WITNESS:

1 A. It can be.

2 BY MS. TROAKE:

3 Q. It can be reversed in 24 hours?

4 A. Yes.

5 Q. In your experience, have you ever had
6 that happen?

7 A. Yes. When a senior executive team
8 decides to terminate a compound, it's not a light
9 switch. A lot of things then need to happen. You
10 have to decide if a patient is receiving drugs, do
11 they continue to get the drug, are you going to
12 enroll new patients, are you going to let the
13 trial complete over the next year and then stop.

14 Termination comes in many flavors. It
15 is very common for an executive team to have a
16 conversation about a drug and make a decision,
17 either yes or no or terminate or extend, and then
18 continue to think about that decision, to talk to
19 the clinical folks, to talk to your lead
20 investigators for a while. And that's typically,
21 as I indicated earlier, a complicated, lengthy set
22 of conversations.

23 In my experience, the only time it's
24 very simple is if there is a life-threatening

1 safety issue with a drug, in which case a decision
2 to terminate is instant and like a light switch.

3 But in most cases, there is a lot of back and
4 forth.

5 Q. Okay. But if the company had gone
6 through a lot of back and forth and went through
7 that complicated discussion, decision-making
8 process, and made the decision to terminate, in
9 your experience, would you expect that it would
10 be -- that decision to terminate after that
11 lengthy process would be reversed within 24 hours?

12 MR. LORENZINI: Objection, incomplete
13 hypothetical; mischaracterizes facts not in
14 evidence.

15 MR. HAKEMI: Objection to form also.

16 BY THE WITNESS:

17 A. It can happen. In clinical trial
18 development, new data comes in, physicians have a
19 point of view, the team has a point of view.
20 Again, if it's a safety issue, it's very clear.

21 BY MS. TROAKE:

22 Q. If it's not a safety issue?

23 A. Things get reversed, people change
24 their minds. It's quite common.

1 Q. Over the course of 24 hours?

2 A. Or months.

3 Q. I guess I am focused on a much shorter
4 time period, not months.

5 A. Have I seen a drug where a company
6 leadership decided to terminate and 24 hours later
7 changed its point of view, yes.

8 Q. And in those instances, was it related
9 to safety?

10 A. No. It was different views about the
11 overall likelihood of the drug being approved and
12 the quality of the drug.

13 Q. In your experience, did that drug
14 eventually make it to market?

15 A. In most cases, no.

16 Q. And in that instance you just
17 described, how long did the drug stay in
18 development after the decision to terminate was
19 reversed?

20 MR. LORENZINI: Objection.

21 BY THE WITNESS:

22 A. Eighteen months.

23 BY MS. TROAKE:

24 Q. I am looking back to Exhibit 8 and the

1 page Bates-labeled 312.

2 A. Yes.

3 Q. This is model May 8 portfolio?

4 A. Yes.

5 Q. Do you have any recollection as to

6 whether ABT-518 and ABT-594 are included in the

7 portfolio as it is represented on this page?

8 A. I have no recollection.

9 MS. TROAKE: This is 9.

10 BY MS. TROAKE:

11 Q. Ms. Hopfield, I put in front of you

12 what has been marked as Exhibit 9.

13 A. Yes.

14 Q. Could you take a look at that, please,

15 and let me know whether you recognize that

16 document.

17 A. Yes.

18 Q. What is it?

19 A. It is the mandate to the various

20 therapeutic teams to pull together therapeutic

21 area presentations for a May off-site.

22 Q. And was this the May off-site, the

23 follow-on to the March off-site that we already

24 talked about?

1 Q. Did anyone else from McKinsey, other
2 than you, participate?

3 A. I don't recall.

4 Q. Did you take any notes in the course of
5 that meeting?

6 A. I don't recall.

7 MS. TROAKE: Here is Exhibit 10.

8 BY MS. TROAKE:

9 Q. I put in front of you what has been
10 marked Exhibit 10.

11 Would you take a look at that, please,
12 and let me know whether you recognize it.

13 A. Yes.

14 Q. And what is it?

15 A. It is a document which Michael Williams
16 and Doane Chilcoat prepared to try and quantify
17 and understand the scope of the new budget and
18 where money was coming from.

19 Q. And was it prepared by McKinsey in the
20 course of its engagement by Abbott during 2001?

21 A. Yes.

22 Q. And was it provided to Abbott in any
23 form during the course of that engagement?

24 A. I don't know for sure, but I believe

1 the answer is no.

2 Q. So this document, like Exhibit 8, you
3 think was an internal McKinsey document?

4 A. Yes. That's its style.

5 Q. What do you mean by that?

6 A. It reads like a fact pack of listing of
7 budgets and listing of facts without a lot of
8 overview or additional analysis. And so it has a
9 style that is consistent with a number of the fact
10 packs that Doane Chilcoat developed just so that
11 we could start to understand frankly what was
12 going on and where the opportunities were.

13 Q. And if you just pull out Exhibit 8 for
14 a second.

15 A. Yeah.

16 Q. Which was the fact pack.

17 A. Yeah.

18 Q. Both Exhibit 8 and this Exhibit 10 on
19 the first page have this short paragraph on the
20 front --

21 A. Yes.

22 Q. -- that talks about the use of the
23 report and it not being distributed outside the
24 client organization.

1 list.

2 A. Yes.

3 Q. They are the last two on that list.

4 Do you recall how this list was
5 compiled and why these particular compounds were
6 characterized by McKinsey as low-ranked projects?

7 MR. LORENZINI: Objection to the form.

8 BY THE WITNESS:

9 A. Similar to what I described before. We
10 took the outcome of the development review and
11 took projects that plausibly were not looking very
12 attractive, and certainly anything that was
13 terminated or hold would fit into that category.
14 So this was our preliminary sense of if you put
15 those together to do the thought exercise of
16 what's the total value.

17 BY MS. TROAKE:

18 Q. Do you recall whether McKinsey
19 ultimately made a recommendation to Abbott to
20 finally terminate ABT-594 and 518?

21 MR. LORENZINI: Objection.

22 BY THE WITNESS:

23 A. We made no recommendations on the
24 termination of any product.

1 BY MS. TROAKE:

2 Q. I put in front of you what has been

3 marked Exhibit 11.

4 If you could take a moment to look at

5 that, please, and let me know whether you

6 recognize that document.

7 A. Yes, I do.

8 Q. And what is it?

9 A. It is an e-mail I sent to Jeff

10 following up on a number of action items from the

11 R&D strategy off-site.

12 Q. Now, the e-mails, both the top e-mail,

13 where you are sending it to Patricia Weber, which,

14 again, as the other e-mail we saw, says, "Please

15 print and put in mail folder." Right?

16 A. Yes.

17 Q. And your e-mail to Mr. Leiden and

18 others are both dated May 6, '01, right?

19 A. Yes.

20 Q. And your e-mail to him at the beginning

21 says, "Jeff, below are a few items from our Friday

22 afternoon session."

23 If you look back at exhibit -- the last

24 one we were looking at -- Exhibit 10, that

1 discussion document is dated May 5, 2001.

2 A. Yes.

3 Q. Which is in and around the time you are

4 sending these e-mails.

5 Does that refresh your recollection at

6 all as to whether that discussion document was

7 used in a meeting with Abbott personnel?

8 MR. LORENZINI: Objection.

9 BY THE WITNESS:

10 A. I do not believe the more that I look

11 at that Exhibit 10 that that would have been used

12 with Abbott personnel. It does not have the style

13 and the kind of content that we would be sharing

14 with the client or a broader team.

15 I believe this was an internal document

16 that Doane Chilcoat developed to help us think

17 about things. There most likely was some document

18 on May 5th, but I do not believe it was that

19 document.

20 BY MS. TROAKE:

21 Q. At the bottom of your e-mail, you have

22 a few bullet points.

23 A. Yes.

24 Q. The second bullet point says, "Previous

1 BY MS. TROAKE:

2 Q. Do you recall getting any response back
3 from Dr. Leiden to this e-mail of May 6, '01?

4 A. I don't recall.

5 Q. Do you recall any discussions with him
6 regarding this e-mail or any of the attachments
7 following that e-mail?

8 A. No.

9 Q. Do you recall hearing from Dr. Leonard
10 or Dr. Leiden or Mr. Funck or Mr. Frapaise or
11 anyone on the R&D steering committee that there
12 was anything incorrect on this initial portfolio
13 prioritization that they had received?

14 MR. LORENZINI: Objection.

15 BY THE WITNESS:

16 A. I don't recall.

17 BY MS. TROAKE:

18 Q. The Friday afternoon session that you
19 refer to in the first paragraph --

20 A. Yes.

21 Q. -- what was that?

22 A. I have no recollection.

23 Q. And you also say that you -- below are
24 a few items for you to pass on as appropriate to

1 the group.

2 Is that reference to the group, do you

3 recall, the same as the one we were just talking

4 about?

5 A. Yes.

6 Q. Do you know whether Mr. Leiden ever

7 forwarded this information to that group?

8 MR. LORENZINI: Objection, calls for

9 speculation.

10 BY THE WITNESS:

11 A. I don't know.

12 BY MS. TROAKE:

13 Q. Looking at the attachments, the first

14 one, the R&D strategy retreat, next steps by TA on

15 project.

16 A. Yes.

17 Q. Is this a document that you created or

18 someone at McKinsey created?

19 A. Yes.

20 Q. And do you know, do you recall what --

21 let me start again.

22 Was this document created in the course

23 of your engagement with Abbott on the Knoll

24 integration?

1 A. Yes.

2 Q. And it was provided to at least

3 Dr. Leiden based on the e-mail, right?

4 A. Yes.

5 Q. Okay. Do you know what the purpose or

6 do you recall what the purpose of this particular

7 document was?

8 MR. LORENZINI: Objection.

9 BY THE WITNESS:

10 A. Yes. They were the transcribed flip

11 chart notes of a discussion about next steps.

12 BY MS. TROAKE:

13 Q. And whose notes were they?

14 A. I don't recall who was at the flip

15 chart.

16 Q. Who was at the what?

17 A. At the flip chart.

18 Q. Okay. So do I have it right, someone

19 is writing on a flip chart?

20 A. Someone is writing, and this is my --

21 my team member transcribing that into an e-mail

22 form, into an electronic form.

23 Q. Do you recall whether the person at the

24 flip chart was an Abbott person or a McKinsey

1 person?

2 A. No, I do not recall.

3 Q. Is it likely that it was a McKinsey

4 person?

5 A. Yes.

6 Q. And why would that be?

7 A. Because that was typically a role that

8 we played in the sessions, was to help facilitate

9 and organize.

10 Q. And the person at the flip chart, would

11 they be just the transcriber of what was being

12 discussed --

13 A. Yes.

14 Q. -- at the meeting?

15 On that document, "R&D strategy

16 retreat," the last item on the first page is

17 ABT-518, and it says, "terminate."

18 A. Yes.

19 Q. Do you recall why that reference was

20 put down on the flip chart, what the discussion

21 was around that?

22 MR. LORENZINI: Objection.

23 BY THE WITNESS:

24 A. No.

1 Q. And in the upper right-hand corner

2 there is a 5/01.

3 Do you see that?

4 A. Yes.

5 Q. Does that indicate you took the notes

6 in May of '01?

7 A. Yes.

8 Q. And do you recall whether these notes

9 were the ones that you took in relation to that

10 Friday session that you referred to in the e-mail

11 we were just looking at?

12 A. I don't recall if it was the Friday

13 session. I think it's more likely to have been

14 the notes from the strategy off-site, from the

15 discussion across TA, which I think was not on a

16 Friday afternoon.

17 Q. Do you recall when that off-site was?

18 A. I could tell from the documents, but I

19 don't recall the dates off the top of my head.

20 Q. One of the documents you have already

21 seen?

22 A. Yes.

23 Q. Which one?

24 A. I think I have seen it. I'm sorry.

1 These would be notes from the R&D strategy retreat

2 as listed on that document. So May 2nd through

3 4th.

4 MR. LORENZINI: Which exhibit?

5 BY MS. TROAKE:

6 Q. You are referring to Exhibit 9?

7 A. Yes.

8 Q. Okay.

9 A. I believe these are my notes from that

10 multiday off-site.

11 Q. And you referenced this page; is that

12 right?

13 A. Correct.

14 Q. Which is Bates-labeled 323307?

15 A. Yes.

16 Q. Okay. And that was May -- I'm sorry,

17 2nd through 4th, did you say?

18 A. Yes, that's my belief.

19 Q. And these notes -- if you could for me,

20 the notes on the first page --

21 A. Yes.

22 Q. -- I couldn't read.

23 A. I understand.

24 Q. If you could just read for me as best

1 5:26 p.m.

2 EXAMINATION

3 BY MR. LORENZINI:

4 Q. I will try to keep this as short as
5 possible.

6 A. All right.

7 Q. Could you turn to Exhibit 15, please.

8 A. This one?

9 Q. Yes.

10 A. Okay.

11 Q. And this is the steering committee
12 presentation entitled May 25, 2001.

13 A. Yes.

14 Q. Could you turn to page 8, please.

15 A. Yes.

16 Q. If you look at the heading on page 8,
17 it says, "Proposed program rationalization."

18 A. Yes.

19 Q. And then below that, it states "2001
20 external savings if terminated, June 1, 2001."

21 A. Yes.

22 Q. Based on the use of the word "proposed"
23 in the heading and then the use of the word "if"
24 in the subheading -- or the column heading, would

1 it be fair to say that ABT-518 had not been

2 terminated as of the date of this May 25, 2001

3 document?

4 MS. TROAKE: Objection.

5 BY THE WITNESS:

6 A. Yes.

7 BY MR. LORENZINI:

8 Q. Could you turn to Exhibit 11, please.

9 A. Yep.

10 Q. And turn to page MCK 410.

11 A. Yes.

12 Q. I believe you testified that this

13 portion of the document reflects someone's

14 transcription of notes from a flip chart.

15 A. Right.

16 Q. Would I be correct in assuming that the

17 notes that were taken on the flip chart did not

18 reflect everything that was said during that

19 meeting?

20 A. Correct.

21 MS. TROAKE: Objection.

22 BY MR. LORENZINI:

23 Q. So there may be additional discussion

24 regarding the compounds listed here beginning on

1 page MCK 410 that was not reflected on the flip

2 charts or in this transcript of the flip charts?

3 A. Yes.

4 MS. TROAKE: Objection.

5 BY MR. LORENZINI:

6 Q. For example, if ABT-518 -- if there was

7 discussion at the early May off-site retreat about

8 terminating 518, if the results released by Pfizer

9 and other companies regarding their MMPI compounds

10 at the ASCO conference was negative, if there was

11 discussion of possibly terminating 518 based on

12 the results of those trials to be released in mid

13 May, that wouldn't necessarily be reflected here?

14 MS. TROAKE: Objection.

15 BY THE WITNESS:

16 A. Right.

17 BY MR. LORENZINI:

18 Q. And you don't recall one way or the

19 other whether there was discussion at this early

20 May meeting about the ASCO conference coming up?

21 A. I don't recall.

22 Q. It might have been discussed, you just

23 can't recall?

24 A. I can't recall.

1 MS. TROAKE: Objection.

2 BY MR. LORENZINI:

3 Q. If you will turn to Exhibit 14, please.

4 A. Yes.

5 Q. And specifically to page MCK 539.

6 A. Yes.

7 Q. And take a look, please, at the top of
8 that page at the bar chart for ABT-594. It's the
9 last bar chart on the top of the page.

10 A. Yes, I have it.

11 Q. And I think you testified that these
12 bar charts reflected the ratings that were
13 assigned by people who were in attendance at the
14 portfolio review meeting.

15 A. That's right.

16 Q. And so am I correct in reading this
17 that -- well, let me first establish, there is
18 some shading for these bar charts, and the
19 shading, the meaning of the shading is represented
20 by what's in the upper right-hand corner, the key?

21 A. Yes.

22 Q. And it says no shading means continue,
23 gray shading means pending and dark shading means
24 eliminate/hold?

1 A. That's right.

2 Q. And so am I correct in reading this

3 that only 14 percent of people in attendance at

4 the portfolio review meeting favored eliminating

5 or holding ABT-594?

6 A. Yes.

7 Q. And, I'm sorry, were these votes, were

8 they a tally of everyone who attended the meeting?

9 A. Yes. This was a -- as a tool, largely

10 to have everyone feel like they were

11 participating. All participants at the meeting

12 were invited to fill out these evaluations. That

13 would have been more than 20 people. I can't

14 remember the total. So it is the full set of

15 people representing Abbott Knoll of cross

16 functions, et cetera.

17 Q. And at that meeting of those people

18 participating in that review, 62 percent favored

19 deferring any decision on ABT-594?

20 MS. TROAKE: Objection.

21 BY THE WITNESS:

22 A. Correct.

23 BY MR. LORENZINI:

24 Q. And that's consistent with what we saw

1 on Exhibit 5, if you could reference that one?

2 A. Yes, it's consistent with that exhibit.

3 Q. And specifically on page 3 of that

4 exhibit, under "Next step," it says, "Await

5 results from ongoing Phase II trial."

6 And is it your recollection that people

7 at the portfolio review meeting favored deferring

8 any decision on ABT-594 until the data from the

9 ongoing Phase II trial were available?

10 MS. TROAKE: Objection.

11 BY THE WITNESS:

12 A. Yes. But to clarify the portfolio

13 prioritization, that column on this is not the

14 outcome of the broad survey. It is the outcome of

15 the executive committee discussion at the end of

16 the day.

17 BY MR. LORENZINI:

18 Q. Okay. So the majority of the broader

19 group that participated in the rating surveys

20 favored deferring any decision?

21 A. Yes.

22 Q. But also the executive group that met

23 at the end similarly favored deferring decision

24 until the results of the Phase II trial were

1 available?

2 A. Right.

3 MS. TROAKE: Objection.

4 BY MR. LORENZINI:

5 Q. And I believe you testified earlier

6 that the probable T on page 3 of Exhibit 5

7 represented a guess by people in that executive

8 group regarding the likelihood of ABT-594

9 continuing and that that was based on their sort

10 of general knowledge and results from studies

11 other than the ongoing Phase II trial?

12 A. Correct.

13 MS. TROAKE: Objection.

14 BY MR. LORENZINI:

15 Q. And you don't recall hearing anything

16 in that discussion about dropout rates in the

17 Phase II trial?

18 MS. TROAKE: Objection.

19 BY THE WITNESS:

20 A. No.

21 BY MR. LORENZINI:

22 Q. And so the probable T does not reflect

23 any assessment based on the Phase II trial since

24 that hadn't been completed yet, correct?

1 MS. TROAKE: Objection.

2 BY THE WITNESS:

3 A. It was their cumulative judgment, which
4 could include some aspects of Phase II. Because
5 although the final results weren't in, they would
6 be aware of some parameters of the trial. So I
7 think it was the collective set of experiences
8 they had with the compound which could have
9 included aspects of the drug.

10 BY MR. LORENZINI:

11 Q. Aspects in terms of the protocol for
12 the trial, the dose ranging aspects of it, et
13 cetera?

14 MS. TROAKE: Objection.

15 BY THE WITNESS:

16 A. Yes. But also comments from
17 investigators, adverse event reports that had gone
18 to the agency and therefore were known.

19 BY MR. LORENZINI:

20 Q. But you don't know -- do you recall
21 anything --

22 A. I don't recall any specific comments.
23 I am simply indicating that that probable T was
24 the full weight of the clinical experiences they

1 had, which would include some sense of what was
2 happening in Phase II.

3 Q. But you don't recall any specific
4 comments about what was going on in Phase II?

5 A. No, I do not.

6 Q. You don't recall any comments about
7 dropout rates in Phase II?

8 MS. TROAKE: Objection.

9 BY THE WITNESS:

10 A. No.

11 BY MR. LORENZINI:

12 Q. And you don't recall any comments about
13 adverse events in Phase II?

14 A. No.

15 MS. TROAKE: Objection.

16 BY MR. LORENZINI:

17 Q. So your testimony just a moment ago
18 about their assessment could include various
19 aspects about adverse events being reported to the
20 FDA, you don't know whether, in fact, that had
21 occurred? Those are just the types of things --

22 A. Those are illustrative things that
23 clinicians will look at, correct.

24 Q. But, in fact, in this particular

1 instance you don't know whether they were basing
2 their guess on that information?
3 A. No.
4 Q. And if you turn back to Exhibit 14,
5 please, that same page we were looking at. That's
6 the one with the bar charts.
7 A. Yes.
8 Q. If you look at the bar chart for 518,
9 ABT-518.
10 A. Uh-huh.
11 Q. Also on page MCK 539.
12 A. Yes.
13 Q. Am I reading it correctly that the
14 majority of the group that participated in this
15 rating survey favored either continuing with the
16 program or deferring decision? And I am looking,
17 specifically adding the 26 percent --
18 A. Yes.
19 Q. -- that favored continuation and the
20 30 percent that favored categorizing it as
21 pending.
22 A. Yes.
23 Q. So a total of 56 percent favored either
24 continuing the program or deferring the decision

1 on continuation?

2 A. Yes.

3 Q. And that's consistent -- is that

4 consistent with the views of the executive group

5 as reflected on Exhibit 5? If you look -- strike

6 that question.

7 If you turn to Page 425 of Exhibit 5.

8 A. Yes.

9 Q. You will see that under "Next steps" on

10 518, it says, "Wait for May results from Pfizer,"

11 "will save \$100 million" and "reevaluate."

12 A. Yes.

13 Q. So the executive group favored

14 deferring any decision on ABT-518 until results --

15 until the reevaluation that was to take place

16 after results were released by Pfizer in May?

17 A. That's right.

18 MS. TROAKE: Objection.

19 BY MR. LORENZINI:

20 Q. And so it was the views of the --

21 strike that.

22 The initial portfolio prioritization

23 document that we have seen, for example, the one

24 that is attached to your e-mail to Jeff Leiden

1 that was marked as Exhibit 5 --

2 A. Yes.

3 Q. -- am I correct you personally only

4 provided a copy of this document to Jeff Leiden?

5 MS. TROAKE: Objection. I think Exhibit 5 is

6 from Michael Williams, the e-mail.

7 MR. LORENZINI: Thank you for that

8 clarification.

9 BY MR. LORENZINI:

10 Q. If you look at Exhibit 5, there is an

11 e-mail, the second e-mail down from Michael

12 Williams to Jeff Leiden attaching the initial

13 portfolio prioritization document.

14 A. Yes.

15 Q. There is no one else from Abbott listed

16 in the "To" or "CC" column.

17 A. Correct.

18 Q. Is it correct, then, that to your

19 knowledge Michael Williams only provided a copy of

20 that document to Jeff Leiden?

21 A. I don't know.

22 Q. You don't know whether he provided it

23 to anyone else?

24 A. That's right.

1 Q. And did you ever provide it to anyone

2 else at Abbott personally?

3 A. I don't know.

4 Q. You don't recall?

5 A. I don't recall.

6 Q. And you don't know whether anyone else

7 at McKinsey provided the initial portfolio

8 prioritization document to anyone?

9 A. I don't recall.

10 Q. Turn to, please, if you would, to

11 Exhibit 8.

12 MS. TROAKE: Which one?

13 MR. LORENZINI: Overview of Abbott R&D fact

14 pack, April of 2001.

15 MS. TROAKE: Thank you.

16 BY THE WITNESS:

17 A. Yes.

18 BY MR. LORENZINI:

19 Q. If you could turn, please, to page

20 MCK 309.

21 A. Yes.

22 Q. Strike that.

23 Turn to page 310, please.

24 A. Yes.

1 Q. If you look under the row that is

2 ABT-518, you will see that priority is listed as

3 H.

4 A. Yes.

5 Q. Is that a reference to hold?

6 A. Yes, it is.

7 Q. And that is a reference to the same

8 thing we saw on the initial portfolio

9 prioritization document --

10 A. That's right.

11 Q. -- the recommendation?

12 MS. TROAKE: Objection, mischaracterizes the

13 prior document.

14 BY MR. LORENZINI:

15 Q. And if you turn to the next page,

16 page 311.

17 A. Yes.

18 Q. You will see there's a few -- there are

19 several compounds listed on that page, and none

20 are listed as hold. They are either listed as

21 terminate, pending or continue. And 518 is listed

22 there as terminate. That terminate doesn't

23 reflect the actual rating that was assigned to

24 ABT-518 at the portfolio review, correct?

1 MS. TROAKE: Objection.

2 BY THE WITNESS:

3 A. Correct.

4 BY MR. LORENZINI:

5 Q. And if you turn back to page 310, I

6 believe -- strike that.

7 I think we have seen on the other

8 documents that ABT-518 was either characterized as

9 hold or hold/T.

10 Is it safe to assume that the

11 information on 311 is an inaccurate or imprecise

12 description of the priority rating that was

13 assigned to ABT-518?

14 A. Yes --

15 MS. TROAKE: Objection.

16 BY THE WITNESS:

17 A. 35 is a thought exercise.

18 BY MR. LORENZINI:

19 Q. And by "thought exercise" -- this

20 page 311 is headed "Potential savings from

21 terminating development projects."

22 A. Exactly. And it also lists terminating

23 some programs that are under a continue, so it was

24 really designed to help us understand, you know,

1 how much money is available.

2 Q. If we decided to terminate?

3 A. Correct.

4 Q. And that is also reflected in the

5 heading over on the right "2001 budget if killed

6 mid May"?

7 A. Yes.

8 Q. So under "Priority," those aren't

9 decisions that have been made, those were just

10 options under consideration?

11 A. Correct.

12 Q. And if you could turn to Exhibit 10,

13 please.

14 MS. TROAKE: Is that the May 5th?

15 MR. LORENZINI: It's the May 5th discussion

16 document.

17 BY MR. LORENZINI:

18 Q. Turn to page MCK 210, please.

19 A. Yes.

20 Q. This page is headed "Potential savings

21 from low-ranked projects." And if you look down

22 at the bottom you will see "Pain-ABT-594,"

23 "Rating," "pending."

24 A. Yes.

1 Q. And then below that, "Oncology

2 ABT-518," "Rating," "terminate/hold."

3 A. Yes.

4 Q. And I know we have seen on some

5 documents ABT-518 was described as having a rating

6 of hold and on others hold/T.

7 A. Yes.

8 Q. Putting that distinction aside, these

9 ratings that are here reflect some of the other --

10 reflect ratings that we have seen in some of the

11 other initial portfolio prioritization documents?

12 A. Correct.

13 Q. ABT-518 was characterized sometimes as

14 hold and sometimes as hold/T?

15 A. Yes.

16 Q. If you turn to page 22 of the document,

17 internal No. 22, Bates MCK 226.

18 A. Yes.

19 Q. This page is headed "Potential savings

20 - pain," and then under 594, it has "Development

21 review rating," "terminate."

22 A. Yes.

23 Q. Does the assignment of the word

24 "terminate" there to 594 -- does that, similarly

1 to the document we just looked at, reflect a
2 thought exercise as to how much would be saved if
3 Abbott decided to terminate 594?

4 A. The page is that thought exercise.
5 That column is reflecting the discussion of the
6 development review.

7 Q. But if you turn back to Exhibit 5, just
8 to refresh your recollection, the rating that was
9 assigned to -- why don't you turn, please, to MCK
10 427 of Exhibit 5.

11 A. Yes.

12 Q. And just read for me there the rating
13 that was assigned to ABT-594 at the March
14 portfolio --

15 A. It's listed there as P.

16 Q. Not T?

17 A. Not T.

18 Q. So am I correct that the accurate
19 description of the development review rating for
20 594 from the March portfolio review was pending?

21 A. Yes.

22 MS. TROAKE: Objection.

23 BY MR. LORENZINI:

24 Q. And is it possible, then, that the

1 listing of terminate on page 22 of the May

2 document we looked at is simply an error?

3 MS. TROAKE: Objection.

4 BY THE WITNESS:

5 A. That is possible. Again, this document

6 was a fact pack developed for -- I believe, for

7 McKinsey internal use, and so I suspect it is

8 plausible there are errors in it.

9 BY MR. LORENZINI:

10 Q. And is that because it's an internal

11 document, it doesn't go through the same sort of

12 quality controls?

13 A. Correct.

14 Q. And if you look at Page 19 of

15 Exhibit 10, you will see 518 is listed there as

16 development review rating terminate, which is

17 inconsistent with what we have seen in the initial

18 portfolio review documents --

19 MS. TROAKE: Objection.

20 BY MR. LORENZINI:

21 Q. -- that listed the priority of 518 as

22 either hold or hold/T.

23 MS. TROAKE: Objection.

24 BY THE WITNESS:

1 A. Yes.

2 BY MR. LORENZINI:

3 Q. And here it's just listed as terminate.

4 A. Yes.

5 Q. Do you believe that is another
6 potential inaccuracy or imprecise description?

7 MS. TROAKE: Objection.

8 BY THE WITNESS:

9 A. I believe in both cases, as I reflect
10 upon it, that because this was a thought exercise,
11 it was important not to have things being pending.
12 They had to be put in a category, you are either
13 continuing in or you are not. And so for the
14 thought exercise of understanding savings, if it
15 was a hybrid category, it would terminate.

16 The right way to do this analysis would
17 be to characterize it as terminate and see what
18 the dollars are. Again, this was not a McKinsey
19 decision or recommendation, but it was simply the
20 thought exercise as to what the money would be.

21 Q. Right. And just going back to Exhibit
22 5 for a moment, the initial portfolio
23 prioritization.

24 A. Yes.

1 Q. I think you testified earlier that the
2 ratings that were assigned to the compounds in
3 this document, those were not -- those don't
4 reflect decisions that had been made, those were
5 options that were under consideration and initial
6 thoughts?

7 A. That was the collective viewpoint of
8 the group at the end of the day.

9 Q. But the decisions as we saw, I think,
10 for some of the timelines regarding budgeting and
11 which projects to continue with, final decisions
12 were to be made in May, correct?

13 A. Correct.

14 MR. LORENZINI: Give me 30 seconds. I will
15 see if I have anything else.

16 (WHEREUPON, there was a short
17 pause.)

18 (WHEREUPON, a certain document
19 was marked Hopfield Deposition
20 Exhibit No. 23 for
21 identification, as of 6/18/07.)

22 BY MR. LORENZINI:

23 Q. Turn to Exhibit 2, please.

24 A. Yes.

1 Q. You may recall earlier you answered
2 some questions regarding Exhibit C2, Deposition
3 Exhibit 2.

4 A. Yes.

5 Q. And that's a document entitled "Meeting
6 mechanics global pharmaceutical R&D strategy
7 retreat, March 2nd through 4th 2001."

8 A. Yes.

9 Q. If you look through the document, you
10 will see -- Exhibit C, that is -- there is
11 reference to TA presentations.

12 A. Yes.

13 Q. And what do you understand TA to mean?

14 A. Therapeutic area.

15 Q. You have before you what has been
16 marked as Exhibit 23.

17 A. Right.

18 MS. TROAKE: Do I have a copy of 23?

19 MR. HAKEMI: Here you go.

20 (WHEREUPON, the document was
21 tendered to Counsel.)

22 MS. TROAKE: Thank you.

23 BY MR. LORENZINI:

24 Q. Exhibit 23 is an e-mail dated April 10,

1 2001, from Beatrice Rendenbach to people at

2 Abbott.

3 A. Yes.

4 Q. And it's attaching -- the e-mail says,

5 "I have just received the attached templates for

6 the strategy retreat from Matthias Lutz."

7 And if you will turn to the third page

8 into the document.

9 A. Yes.

10 Q. You will see another copy of what was

11 shown to you before as Exhibit C of Exhibit 2.

12 A. Yes.

13 Q. And it's also titled "Meeting

14 mechanics, March 2nd through 4th, 2001."

15 A. Yes.

16 Q. And do you recall that the off-site

17 meeting that took place in May was May 2nd through

18 4th? I think we saw that in some of the earlier

19 documents.

20 A. I think that's right. I am getting

21 tired, so I am getting fuzzy on the dates, but,

22 yes.

23 Q. I am wondering here, given the fact

24 that March 2nd through -- there is a reference to

1 dates of 2nd through 4th in this meeting mechanics
2 document --
3 A. Yes.
4 Q. -- and also just looking through the
5 substance of the document, I am wondering if it's
6 possible this meeting mechanics document, that the
7 March is a mistake and that is actually a meeting
8 mechanics document for the May 2nd through 4th
9 off-site meeting.
10 Maybe you can take a second to look
11 through it to look at what the agenda is.
12 A. I am embarrassed to say I think you
13 are, in fact, correct because the second meeting
14 in May was, in fact, very focused on the
15 therapeutic areas and had the kind of overviews of
16 the TA presentations that are listed here as well
17 as the fact that the e-mail is, in fact, occurring
18 on April 10th, which is after March. So that is
19 the likely explanation, yes. These are the kind
20 of therapeutic area presentations the strategy
21 retreat was focused on.
22 MR. LORENZINI: I think those are all the
23 questions that I have. Yeah, that's all I have.
24 Thank you very much.

DEPOSITION EXHIBIT 4

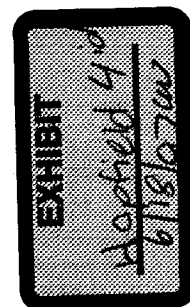
PLT'S EXHIBIT FC

CH-228011-049-MADRAS/jbrd

BUILDING A WORLD OF OPPORTUNITIES TOGETHER



Development portfolio review kick-off
March 7, 2001



CH-228011-049-MADRAS/jbrd

STRUCTURE OF PRESENTATION

PAGE NOT TO BE INCLUDED IN PRESENTATION

J. Leiden

Slides

- Introduction (page 2)
 - Who "we" are (page 3)
 - Objectives (page 4)
 - Decision-making approach (page 5)
-
- Ground rules (page 6)
 - Agenda (pages 7-9)

J. Leonard

CH-228011-049-MADRAS/jbrd

INTRODUCTION

- Our goal is to be the world's premier health care company
- Together we must build a leading, global R&D portfolio by leveraging our
 - Outstanding scientists
 - Exciting technologies
 - Scale
 - Global reach
- This unified portfolio review process is the first step in achieving our goal
 - Success will require tough choices

CH-228011-049-MADRAS/jbrd

WHO “WE” ARE – COMBINED STRENGTH

People

- Total employees 70,700
- Number of scientists 5,400

Pipeline

- Preclinical >30
- In development 46
 - Phase 1 16
 - Phase 2 17
 - Phase 3 13
- Filed 5

Capabilities

- Total facilities 156
- Manufacturing sites 67
worldwide
- Global pharmaceutical R&D investment ~\$950 million

CH-228011-049-MADRAS/jbrd

OBJECTIVES FOR THIS WEEK'S REVIEW MEETING

- To gain a shared understanding of all development projects across the new company
- To identify the critical issues, timelines, and upcoming decisions for each project, emphasizing
 - Clinical
 - Commercial merits
- To provide senior management with the technical inputs necessary to make portfolio decisions over the coming weeks

CH-228011-049-MADRAS/jbrd

DECISION-MAKING APPROACH GOING FORWARD

What

- Classify products into three groups
 1. Projects to definitely retain
 2. Projects warranting further discussion/assessment
 3. Projects which will not be retained

When

- Initial list of projects in the third group will be communicated within 1-2 weeks
- All other projects to continue as planned until final prioritization completed by early May

How

- Single uniform process across the combined portfolio
- Consistent set of criteria to evaluate all project opportunities

CH-228011-049-MADRAS/jbrd

MEETING GROUND RULES

Presenters

- Provide fact-based, objective perspective on the project
 - Focus on most important issues (given time constraint)
 - Identify critical milestones and funding requirements
 - Propose the product plan and give your rationale
- Stay for presentations within own individual therapeutic area/venture groups

Audience

- Ask questions of clarification during the time allocated for discussion
- Respect time constraints
- Maintain strict confidentiality of the material presented

CH-228011-049-MADRAS/jbrd

AGENDA – WEDNESDAY, MARCH 7

	Welcome/Introduction Meeting objectives	Presentation 10 minutes 10 minutes	Discussion	Presenter J. Leiden J. Leonard
7:30 a.m. 7:40 a.m.				
	Anti-infectives ABT-492 HSR-903	20 minutes 30 minutes	5 minutes 10 minutes	C. Craft T. Hirose/R. Krauthmeier
7:50 a.m. 8:15 a.m.				
	Anti-virals Triangle projects • HIV and HBV (FTC; DAPD)	30 minutes	10 minutes	M. Health-Chiozzi
8:55 a.m.				
9:35 a.m.	<i>Morning Break</i>			
	Urology BSF 42027 (ETA/BPH)	30 minutes	10 minutes	M. Luz/U. Legler
9:55 a.m.				
	Asthma Hokunalin tape	15 minutes	5 minutes	T. Hirose/R. Krauthmeier
10:35 a.m.				
	Oncology ABT-510 ABT-751	20 minutes 20 minutes	15 minutes 15 minutes	P. Nisen P. Nisen
10:55 a.m. 11:30 a.m.				
12:05 p.m.	<i>Lunch</i>			
	ABT-518 Rubitecan Theragyn ABT-627	15 minutes 20 minutes 20 minutes 30 minutes	5 minutes 5 minutes 5 minutes 10 minutes	P. Nisen P. Nisen P. Nisen P. Nisen
1:05 p.m. 1:25 p.m. 1:50 p.m. 2:15 p.m.				
2:50 p.m.	<i>Afternoon break</i>			
	Cardiology Darusentan (LU 135252) and other ETAs	30 minutes	10 minutes	M. Luz/U. Legler
3:15 p.m.				
	Thrombosis PEG-hirudin Ancord Urokinase/Pro-urokinase	30 minutes 30 minutes 30 minutes	10 minutes 10 minutes 10 minutes	V. Ifthekar/U. Legler N. Bender S. Gupta
3:55 p.m. 4:35 p.m. 5:15 p.m.				

CH-228011-049-MADRAS/jbrd

AGENDA – THURSDAY, MARCH 8

		Presentation	Discussion	Presenter
7:30 a.m.	Neuroscience			
8:10 a.m.	ABT 594	30 minutes	10 minutes	B. McCarthy
8:40 a.m.	ABT-963	15 minutes	15 minutes	Granneman/Doan/Bell
	BSF 201640	30 minutes	10 minutes	B. Rendenbach-Mueller/B.
9:20 a.m.	BSF 74398	30 minutes	10 minutes	Hargan
	(Parkinson)			
10:00 a.m.	<i>Morning Break</i>			
10:20 a.m.	Dilaudid OROS	45 minutes	15 minutes	B. Gold/R. Krauthmeimer
11:20 a.m.	BSF 190555	30 minutes	10 minutes	B. Rendenbach-Mueller/B.
	(Schizophrenia)			Hargan
12:00 p.m.	<i>Lunch</i>			
1:00 p.m.	Hydrocodone	10 minutes	10 minutes	Abbott (TBD)
1:20 p.m.	Blmoclomol (ABT-822)	30 minutes	10 minutes	B. Wallin
2:00 p.m.	Gastro-enterology	15 minutes	5 minutes	S. Dawe/R. Krauthmeimer
2:20 p.m.	Ganaton (pro-kinetic)	30 minutes	10 minutes	T. Hirose/ R. Krauthmeimer
3:00 p.m.	TU-199 (proton pump inh.)	20 minutes	5 minutes	T. Hirose/ R. Krauthmeimer
	AU-224 (colon pro-kinetic)			
3:25 p.m.	<i>Afternoon break</i>			
3:45 p.m.	Phase III Projects	30 minutes	15 minutes	C MacLeod
4:30 p.m.	Levosimendan	30 minutes	15 minutes	A. Pethö-Schramm/U. Legler
5:15 p.m.	Rythmol SR	45 minutes	30 minutes	C. Spiegler/E. v. Borcke
	D2E7			

CH-228011-049-MADRAS/jbrd

AGENDA – FRIDAY, MARCH 9

	Phase III (Continued)	Presentation	Discussion	Presenter
7:30 a.m.	Segard	45 minutes	15 minutes	L. Daum/E. v. Borcke
8:30 a.m.	J695	30 minutes	10 minutes	R. Janocha/E. v. Borcke
9:10 a.m.	Clivarine	30 minutes	15 minutes	F. Misselwitz/U. Legler
9:55 a.m.	<i>Morning break</i>			
10:15 a.m.	ABT-773	30 minutes	15 minutes	C. Craft
11:00 a.m.	Phase IV Projects			
11:20 a.m.	Clarithromycin	15 minutes	5 minutes	C. Olson
11:40 a.m.	Omnicef	15 minutes	5 minutes	C. Olson
12:00 p.m.	Kaletra	15 minutes	5 minutes	E. Sun
	Norvir	15 minutes	5 minutes	E. Sun
12:20 p.m.	<i>Lunch</i>			
1:20 p.m.	Meridia (Sibutramine)	15 minutes	5 minutes	E. Chong/W. Hargan
1:40 p.m.	Uprima	15 minutes	5 minutes	S. Bukofzer
2:00 p.m.	Trandolapril (patch, intervention trials)	15 minutes	5 minutes	B. Rendbach-Mueller/ U. Legler/N. Bender
2:20 p.m.	Fenofibrate	15 minutes	5 minutes	D. Yannicelli
2:40 p.m.	Depakote	15 minutes	5 minutes	K. Sommerville
3:00 p.m.	Gengraf	15 minutes	5 minutes	T. Japour
3:20 p.m.	Conclusion			J. Leiden

DEPOSITION EXHIBIT 5


PLT'S EXHIBIT FH

Jessica Hopfield
03/13/2001 07:22 PM

To: Patricia Weber/NJE/NorthAmerica/MCKINSEY@MCKINSEY
cc:
Subject: Please print and put in mail folder

----- Forwarded by Jessica Hopfield/NJE/NorthAmerica/MCKINSEY on 03/13/2001 07:23 PM -----

Michael Williams
03/13/2001 04:10 PM

To: Jeff Leiden <jeff.leiden@Abbott.com>
cc: Jessica Hopfield/NJE/NorthAmerica/MCKINSEY@MCKINSEY, Dick
Ashley/CHI/NorthAmerica/MCKINSEY@MCKINSEY, David
Keeling/CHI/NorthAmerica/MCKINSEY@MCKINSEY
Subject: List of next steps from portfolio review 

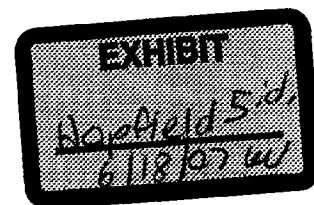
Jeff,

Please find attached a detailed list of the next steps by project, coming out of last week's development review. Where possible, we have assigned the responsibilities and timings we picked up during the discussions. You may wish to make changes to the list before it is more broadly distributed and we can make edits based on your handwritten comments if necessary.

We are also in the process of compiling the comments and results from the evaluation forms which we'll forward to you by later this week.



NEXT STEPS - development portfolio prioritization



INITIAL PORTFOLIO PRIORITIZATION

Project	Priority	Next steps	Responsibility	Timing
Anti-infectives				
ABT-492	C	<ul style="list-style-type: none"> • Address safety issues (including QTc) with internal/expert review • Determine how many indications at launch (pay back) 	• J. Leonard	-
HSR-903	T	<ul style="list-style-type: none"> • Consider trading with Daiichi • Halt any new expenditure 	• J. Tyree	-
ABT-773	C	<ul style="list-style-type: none"> • Assess side effects issues with expert review (QTc and liver tox.) • Ensure all drug interactions are adequately covered • Assess relative to Ketek 	• J. Leonard • J. Leonard • I. Loew	-
Urology				
BSF 420627	P	<ul style="list-style-type: none"> • Set up task force to address issues and bring back plan to senior management <ul style="list-style-type: none"> - Reasons for failure of the SKB ETa/b antagonist - Design short (~4 week) PoP trial for symptom relief - Rationale for sustained release formulation - Nature of the Schwarz Pharma relationship 	• J. Leonard	• By May
Hypothyroidism				
T3/T4	P	<ul style="list-style-type: none"> • Assess most appropriate ratio • Gain FDA feedback on study design • Determine ex-US market attractiveness (price) 	• J. Leonard	• By May
Asthma				
Hokunalin tape	P	<ul style="list-style-type: none"> • Conduct market research on acceptance by different patient segments • Determine how to position against long acting beta agonists and combination inhalers • Evaluate opportunity to gain complete access to the patch technology 	• A. Higgins/ E. Fiorentino • J. Tyree	• May

0

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
Oncology ABT-510	C	<ul style="list-style-type: none"> Pursue proof of concept Leverage TAP knowledge of angiogenesis product development (appropriate endpoints) 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> As planned
ABT-751	C	<ul style="list-style-type: none"> Pursue proof of concept Use echocardiogram to monitor potential cardiotoxicity Resolve potent drug manufacturing approach 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> As planned
ABT-518	Hold	<ul style="list-style-type: none"> Wait for May results from Pfizer (will save ~\$1mill) and re-evaluate Halt all further expenditure 	<ul style="list-style-type: none"> CMC group Senior management 	<ul style="list-style-type: none"> May
Rubitecan	P	<ul style="list-style-type: none"> Significant clinical rework required (funded by partner)- further in-depth review required Make a proceed decision when 2Q data available 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> By May
Theragyn	P	<ul style="list-style-type: none"> Negative initial scientific perspective - further in-depth review required, e.g., <ul style="list-style-type: none"> Determine if there is a PoC to support claim Address GMP issues Determine best control to demonstrate efficacy Re-look at partnership contract 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> By May
ABT-627	C	<ul style="list-style-type: none"> Seek alternative funding (e.g., NCI) before starting major trial If move ahead <ul style="list-style-type: none"> Determine how to ensure NDA filing in 2004 Get FDA input since survival not primary endpoint Harmonize US and EU study design and inputs Consider partnership (e.g., BI or established oncology player) 	<ul style="list-style-type: none"> J. Tyree J. Leonard, P. Nisen 	<ul style="list-style-type: none"> By May ASAP
			<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> By May

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
Cardiology/ thrombosis Darusentan (LU 135252)	Hold	<ul style="list-style-type: none"> • Continue currently budgeted funding for next 6 months • Do not start any new trials (e.g., hypertension planned for May) • If proceed, plan for pilot to look at effects in sperm and tetragonogenicity • Consider out-license or swap 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • Ongoing
LU 208075	Hold	<ul style="list-style-type: none"> • Continue currently budgeted funding for next six months • Look at Myogen deal • Out-license or swap 	<ul style="list-style-type: none"> • J. Tyree • Project team • J. Tyree 	<ul style="list-style-type: none"> • ASAP • ongoing
Levosimendan	C	<ul style="list-style-type: none"> • Conduct detailed expert panel review for trial design 	<ul style="list-style-type: none"> • J. Leonard 	<ul style="list-style-type: none"> • May
PEG-hirudin	P	<ul style="list-style-type: none"> • Set up expert panel for commercial assessment (is diabetes an option?) 	<ul style="list-style-type: none"> • E. Ogunro 	<ul style="list-style-type: none"> • By May
Ancrod	T	<ul style="list-style-type: none"> • Identify out-licensing opportunities 	<ul style="list-style-type: none"> • J. Tyree 	<ul style="list-style-type: none"> • TBD
Urokinase	P	<ul style="list-style-type: none"> • Market research required on open cath • Match versus tPA in dose-ranging studies to determine efficacy 	<ul style="list-style-type: none"> • E. Fiorentino 	<ul style="list-style-type: none"> • By May
Pro-urokinase	C	<ul style="list-style-type: none"> • Identify opportunities to speed up program 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • TBD
Clivarine	C	<ul style="list-style-type: none"> • Assessment by HPD (review previous evaluation and new trial data) • Understand finished product manufacturing cost 	<ul style="list-style-type: none"> • E. Ogunro • B. Dempsey 	<ul style="list-style-type: none"> • By May
Rythmol SR	C	<ul style="list-style-type: none"> • Continue filing • Verify if package is likely approvable • Assess commercial attractiveness in a generic market 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • Ongoing

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Neuroscience ABT 594	P	<ul style="list-style-type: none"> • Await results from ongoing PII trial – probable T • Project team to develop decision criteria for go/no go 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • June/ July
ABT 963	C	<ul style="list-style-type: none"> • Identify a co-development/co-promotion partner (TAP high on list) • Evaluate benefits of the long half life in pain and cancer (including additional physician market research) • Explore cancer prophylaxis and Alzheimer's indications 	<ul style="list-style-type: none"> • J. Tyree • Project team 	<ul style="list-style-type: none"> • TBD
BSF 201640	P	<ul style="list-style-type: none"> • Complete review of all schizophrenia NCEs with expert panel • Complete staffing of internal project team, but halt further expenditure beyond looking at hepatic tox. and QTc • Understand Novartis contract and level of interest 	<ul style="list-style-type: none"> • I. Loew • Project team 	<ul style="list-style-type: none"> • By May
BSF 190555	P	<ul style="list-style-type: none"> • Complete review as above • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • J. Tyree • I. Loew 	<ul style="list-style-type: none"> • As above
BSF 74398	C	<ul style="list-style-type: none"> • Allow DevCo to continue development • Re-look at relationship with DevCo 	<ul style="list-style-type: none"> • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
Diluadid Oros Hydrocodone	Hold C	<ul style="list-style-type: none"> • Return to ALZA or out-license to other interested partner • Assess regulatory pathway • Understand DEA impact on manufacturing 	<ul style="list-style-type: none"> • J. Tyree • Project team 	<ul style="list-style-type: none"> • TBD • By May
Bimoclonol (ABT 822)	P	<ul style="list-style-type: none"> • Await data from ongoing trial in April before deciding whether to continue - probable T • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • April

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
<p>Gastro-enterology</p> <p>Ganaton</p> <p>P</p> <ul style="list-style-type: none"> • Conduct U.S. commercial assessment with TAP • Assess how to position in Europe versus generics and implications for comparative trial • Develop model to assess spend at different termination points <p>TU-199</p> <p>AU-224</p> <p>T</p> <ul style="list-style-type: none"> • Terminate outside Japan <p>C</p> <ul style="list-style-type: none"> • Develop and pursue a small PoC trial in humans ASAP (consider niche indication first and leverage Marlene's expertise) • Conduct market research on IBS versus constipation (including pricing) <p>Immunology</p> <p>D2E7</p> <p>C</p> <ul style="list-style-type: none"> • Conduct intensive product review <ul style="list-style-type: none"> - 2 day meeting with J. Lennard's group (already in process) - ½ day session with senior management group • Important actions include <ul style="list-style-type: none"> - Approach FDA for fast track and compassionate use - Develop strategy for DMARD claim in first submission - Assess need for Enbrel assay to detect HAHAs - Assess delivery device options - Evaluate additional indications (e.g., Psoriasis, Crohns, heart failure) and pediatric program - Profile Celltech product - Assess impact of additional IV program on reimbursement • Develop list of potential marketing partners for quids 				
			• E. Fiorentino	• By June
			• Bob Funck	• By May
			• Project team	• Immediate
			• Project team	• ASAP
			• E. Fiorentino	
			• J. Leonard	• By May
			• Various	• By May
			• J. Tyree	

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C-continue
P-pending
T-terminate

Project	Priority	Next steps	Responsibility	Timing
Immunology (continued) Segard	Hold	<ul style="list-style-type: none"> • Continue filling in EU and Canada • Put on hold in US – consider creating a small team in the US to analyse data, propose smaller PII study • Research pricing, marketing and Phase IV plans in Europe • Look at TNF-alpha levels retrospectively to see stratification with IL-6 • Assess manufacturing strategy • Identify potential out-licensing opportunities (Genentech) 	<ul style="list-style-type: none"> • Project team • J. Leonard 	<ul style="list-style-type: none"> • Ongoing
J695	P	<ul style="list-style-type: none"> • Decide on most attractive indications from Abbott and partner perspective • Discuss with partner ways to share the various indications and potential for TNF-alpha combinations • Add commercial person to the project team by this week 	<ul style="list-style-type: none"> • J. Tyree • E. Fiorentino • J. Tyree • Ongoing 	<ul style="list-style-type: none"> • ASAP

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
PIV programs				
Clarithromycin	C	• None identified	-	-
Ornicef	C	• Talk to partners	• J. Tyree	-
Kaetra	C	• None identified	-	-
Norvir	C	• None identified	-	-
Meridia	Hold	• Conduct commercial assessment for CNS and depression (P&L)	• B. Dempsey, J. Arnott, E. Fiorentino	• ASAP
		• Assess combination therapy with fibrates		
		• Assess outcomes trial design to meet preferred commercial profile; determine payback	• Project team	
Uprima	C	• Ensure no redundant trials with TAP in Europe	• Project team	• Ongoing
Trandolapril patch	T	• Halt all activities	• Project team	• Immediate
Trandolapril "Invest" clinical program	P	• Review trial in more detail (reduce complexity and risk)	• E. Fiorentino	• By May
Other trandolapril trials	C	• Continue "Create", "Peace" and "Benedict" trial programs	• Project team	• Ongoing
Fenofibrate	C	• Develop co-formulation ideas with Meridia and statins (including assessment of sales and costs)	• Project team	-
Depakote	C	• None identified	-	-
Gengraf	C	• None identified	-	-

DEPOSITION EXHIBIT 6

PLT'S EXHIBIT GW

CH-CH-228013-013jb/aard

INITIAL PORTFOLIO PRIORITIZATION

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Anti-Infectives ABT-492	C	<ul style="list-style-type: none"> Address safety issues (including QTc) with internal/ expert review Determine how many indications at launch (pay back) 	• J. Leonard	-
HSR-903	T	<ul style="list-style-type: none"> Consider trading with Daiichi Halt any new expenditure 	• J. Tyree	-
ABT-773	C	<ul style="list-style-type: none"> Assess side effects issues with expert review (QTc and liver tox.) Ensure all drug interactions are adequately covered Assess relative to Ketek 	<ul style="list-style-type: none"> • J. Leonard • J. Leonard • I. Loew-Friedrich 	-
Urology BSF 420627	P	<ul style="list-style-type: none"> Set up task force to address issues and bring back plan to senior management <ul style="list-style-type: none"> Reasons for failure of the SKB ETa/b antagonist Design short (~4 week) PoP trial for symptom relief Rationale for sustained release formulation Nature of the Schwarz Pharma relationship 	• J. Leonard	• By May
Hypothyroidism T3/T4	P	<ul style="list-style-type: none"> Assess most appropriate ratio Gain FDA feedback on study design Determine ex-US market attractiveness (price) 	• J. Leonard	• By May
Asthma Hokunalin tape	P	<ul style="list-style-type: none"> Conduct market research on acceptance by different patient segments Determine how to position against long acting beta agonists and combination inhalers Evaluate opportunity to gain complete access to the patch technology 	<ul style="list-style-type: none"> • A. Higgins/ E. Fiorentino • J. Tyree 	• May



CH-CH-228013-013b/aaRD

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Oncology ABT-510	C	<ul style="list-style-type: none"> Pursue proof of concept Leverage TAP knowledge of angiogenesis product development (appropriate endpoints) 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> As planned
ABT-751	C	<ul style="list-style-type: none"> Pursue proof of concept Use echocardiogram to monitor potential cardiotoxicity Resolve potent drug manufacturing approach 	<ul style="list-style-type: none"> Project team CMC group Senior management 	<ul style="list-style-type: none"> As planned
ABT-518	Hold/T	<ul style="list-style-type: none"> Wait for May results from Pfizer (will save ~\$1mill) and re-evaluate Halt all further expenditure 	<ul style="list-style-type: none"> Senior management 	<ul style="list-style-type: none"> May
Rubitecan	P	<ul style="list-style-type: none"> Significant clinical rework required (funded by partner)- further in-depth review required Make a proceed decision when 2Q data available 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> By May
Theragyn	P	<ul style="list-style-type: none"> Negative initial scientific perspective - further in-depth review required, e.g., <ul style="list-style-type: none"> Determine if there is a PoC to support claim Address GMP issues Determine best control to demonstrate efficacy Re-look at partnership contract 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> By May
ABT-627	C	<ul style="list-style-type: none"> Seek alternative funding (e.g., NCI) before starting major trial If move ahead <ul style="list-style-type: none"> Determine how to ensure NDA filing in 2004 Get FDA input since survival not primary endpoint Harmonize US and EU study design and inputs Consider partnership (e.g., BI or established oncology player) 	<ul style="list-style-type: none"> J. Tyree J. Leonard, P. Nisen 	<ul style="list-style-type: none"> By May ASAP
			<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> By May

CH-CH-228013-013jb/aaRD

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Cardiology/ thrombosis Darusentan (LU 135252)	Hold/T	<ul style="list-style-type: none"> Continue currently budgeted funding for next 6 months Do not start any new trials (e.g., hypertension planned for May) Consider out-license or swap 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> Ongoing
LU 208075	Hold/T	<ul style="list-style-type: none"> Continue currently budgeted funding for next six months Look at Myogen deal Out-license or swap 	<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> ASAP
Levosimendan	C	<ul style="list-style-type: none"> Conduct detailed expert panel review for trial design 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> May
PEG-hirudin	P	<ul style="list-style-type: none"> Set up expert panel for commercial assessment (is diabetes an option?) 	<ul style="list-style-type: none"> E. Ogunro 	<ul style="list-style-type: none"> By May
Ancrod	T	<ul style="list-style-type: none"> Identify out-licensing opportunities 	<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> TBD
Urokinase	P	<ul style="list-style-type: none"> Market research required on open cath Match versus tPA in dose-ranging studies to determine efficacy 	<ul style="list-style-type: none"> E. Fiorentino 	<ul style="list-style-type: none"> By May
Pro-urokinase	C	<ul style="list-style-type: none"> Identify opportunities to speed up program 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> TBD
Clivarine	C	<ul style="list-style-type: none"> Assessment by HPD (review previous evaluation and new trial data) Understand finished product manufacturing cost 	<ul style="list-style-type: none"> E. Ogunro 	<ul style="list-style-type: none"> By May
Rythmol SR	C	<ul style="list-style-type: none"> Continue filing Verify if package is likely approvable Assess commercial attractiveness in a generic market 	<ul style="list-style-type: none"> B. Dempsey Project team 	<ul style="list-style-type: none"> Ongoing

CH-CH-228013-013b/aarD

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Neuroscience ABT 594	P	<ul style="list-style-type: none"> • Await results from ongoing PII trial -- probable T • Project team to develop decision criteria for go/no go 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • June/ July
ABT 963	C	<ul style="list-style-type: none"> • Identify a co-development/co-promotion partner (TAP high on list) • Evaluate benefits of the long half life in pain and cancer (including additional physician market research) • Explore cancer prophylaxis and Alzheimer's indications 	<ul style="list-style-type: none"> • J. Tyree • Project team 	<ul style="list-style-type: none"> • TBD
BSF 201640	P	<ul style="list-style-type: none"> • Complete review of all schizophrenia NCEs with expert panel • Complete staffing of internal project team, but halt further expenditure beyond looking at hepatic tox. and QTC • Understand Novartis contract and level of interest 	<ul style="list-style-type: none"> • I. Loew-Freidrich • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
BSF 190555	P	<ul style="list-style-type: none"> • Complete review as above • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • I. Loew-Freidrich 	<ul style="list-style-type: none"> • As above
BSF 74398	C (no cost)	<ul style="list-style-type: none"> • Allow DevCo to continue development • Re-look at relationship with DevCo 	<ul style="list-style-type: none"> • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
Diluadid Oros	Hold/T	<ul style="list-style-type: none"> • Return to ALZA or out-license to other interested partner 	<ul style="list-style-type: none"> • J. Tyree 	<ul style="list-style-type: none"> • TBD
Hydrocodone	C	<ul style="list-style-type: none"> • Assess regulatory pathway • Understand DEA impact on manufacturing 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • By May
Blimocromol (ABT 822)	P	<ul style="list-style-type: none"> • Await data from ongoing trial in April before deciding whether to continue - probable T • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • April

CH-CH-228013-013/b/aarD

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Gastro-enterology Ganaton	P	<ul style="list-style-type: none"> • Conduct U.S. commercial assessment with TAP • Assess how to position in Europe versus generics and implications for comparative trial • Develop model to assess spend at different termination points 	<ul style="list-style-type: none"> • E. Fiorentino 	<ul style="list-style-type: none"> • By June
TU-199	T	<ul style="list-style-type: none"> • Terminate outside Japan 	<ul style="list-style-type: none"> • Bob Funck 	<ul style="list-style-type: none"> • By May
AU-224	C	<ul style="list-style-type: none"> • Develop and pursue a small PoC trial in humans ASAP (consider niche indication first and leverage Marlene's expertise) • Conduct market research on IBS versus constipation (including pricing) 	<ul style="list-style-type: none"> • Project team • Project team 	<ul style="list-style-type: none"> • Immediate • ASAP
Immunology D2E7	C	<ul style="list-style-type: none"> • Conduct intensive product review <ul style="list-style-type: none"> - 2 day meeting with J. Leonard's group (already in process) - ½ day session with senior management group • Important actions include <ul style="list-style-type: none"> - Approach FDA for fast track and compassionate use - Develop strategy for DMARD claim in first submission - Assess need for Enbrel assay to detect HAHAs - Assess delivery device options - Evaluate additional indications (e.g., psoriasis, Crohns, heart failure) and pediatric program - Profile Celltech product - Assess impact of additional IV program on reimbursement • Develop list of potential marketing partners for quids 	<ul style="list-style-type: none"> • J. Leonard • Various 	<ul style="list-style-type: none"> • By May • By May
			<ul style="list-style-type: none"> • J. Tyree 	

CH-CH-228013-013j/aaRD

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Immunology (continued) Segard	Hold	<ul style="list-style-type: none"> • Continue filing in EU and Canada • Put on hold in US – consider creating a small team in the US to analyse data, propose smaller PII study • Research pricing, marketing and Phase IV plans in Europe • Look at TNF-alpha levels retrospectively to see stratification with IL-6 • Assess manufacturing strategy • Identify potential out-licensing opportunities (Genentech) 	<ul style="list-style-type: none"> • Project team • J. Leonard 	<ul style="list-style-type: none"> • Ongoing
J695	P	<ul style="list-style-type: none"> • Decide on most attractive indications from Abbott and partner perspective • Discuss with partner ways to share the various indications and potential for TNF-alpha combinations • Add commercial person to the project team by this week 	<ul style="list-style-type: none"> • J. Tyree • E. Fiorentino • J. Tyree • Ongoing 	<ul style="list-style-type: none"> • ASAP

CH-CH-228013-013/b/aarD

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
PIV programs				
Clarithromycin	C	• None identified	-	-
Ornicef	C	• None identified	-	-
Kaletra	C	• None identified	-	-
Norvir	C	• None identified	-	-
Meridia	Hold	<ul style="list-style-type: none"> • Conduct commercial assessment for CNS and depression (P&L) • Assess combination therapy with fibrates • Assess outcomes trial design to meet preferred commercial profile; determine payback 	<ul style="list-style-type: none"> • B. Dempsey, J. Arnott, E. Fiorentino • Project team 	<ul style="list-style-type: none"> • ASAP
Uprima	C	• Ensure no redundant trials with TAP in Europe	• Project team	• Ongoing
Trandolapril patch	T	• Halt all activities	• Project team	• Immediate
Trandolapril "invest" clinical program	P	• Review trial in more detail (reduce complexity and risk)	• E. Fiorentino	• By May
Other trandolapril trials	C	• Continue "Create", "Peace" and "Benedict" trial programs	• Project team	• Ongoing
Fenofibrate	C	• Develop co-formulation ideas with Meridia and statins (including assessment of sales and costs)	• Project team	-
Depakote	C	• None identified	-	-
Gengraf	C	• None identified	-	-

DEPOSITION EXHIBIT 7

PLT'S EXHIBIT FI

CONFIDENTIAL

R&D Integration Update



Discussion document

March 19, 2001

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CH-228011-076jism/cgDC

AGENDA



- Update on the development portfolio review
- Overview of the phase 2 R&D integration plan
- Update on the financial baseline
- Preliminary synergy opportunities

1

CH-228011-076jsm/cgDC

TIMELINE TO FINALIZE THE PHARMA R&D PROGRAM

Review	Date	Responsibility
Global development review	March 7-9	John Leonard
Budget baseline finalized	April 2	Bob Funck
Global discovery reviews	April 22-24	Dan Norbeck
Portfolio analysis Abbott and Knoll compounds	April 20	Keith Hendricks
Global pharma R&D strategy retreat	May 4-6	TBD*
Final pharma R&D program	May 8	Pharma Executive Management Committee

* Head of discovery, venture head, and commercial representative for each therapeutic area to present individual strategies

INITIAL PORTFOLIO PRIORITIZATION

CH-228011-076ism/cgDC
 C- Continue
 P- Pending
 T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Anti-infectives				
ABT-492	C	<ul style="list-style-type: none"> Address safety issues (including QTc) with internal/expert review Determine how many indications at launch (pay back) 	• J. Leonard	-
HSR-903	T	<ul style="list-style-type: none"> Consider trading with Daiichi Halt any new expenditure 	• J. Tyree	-
ABT-773	C	<ul style="list-style-type: none"> Assess side effects issues with expert review (QTc and liver tox.) Ensure all drug interactions are adequately covered Assess relative to Ketek 	• J. Leonard • J. Leonard • I. Loew	-
Urology				
BSF 420627	P	<ul style="list-style-type: none"> Set up task force to address issues and bring back plan to senior management <ul style="list-style-type: none"> Reasons for failure of the SKB ETa/b antagonist Design short (~4 week) PoP trial for symptom relief Rationale for sustained release formulation Nature of the Schwarz Pharma relationship 	• J. Leonard	• By May
Hypothyroidism				
T3/T4	P	<ul style="list-style-type: none"> Assess most appropriate ratio Gain FDA feedback on study design Determine ex-US market attractiveness (price) 	• J. Leonard	• By May
Asthma				
Hokunalin tape	P	<ul style="list-style-type: none"> Conduct market research on acceptance by different patient segments Determine how to position against long acting beta agonists and combination inhalers Evaluate opportunity to gain complete access to the patch technology 	• A. Higgins/ E. Fiorentino	• May
			• J. Tyree	3

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

CH-228011-076ism/cgDC
 C- Continue
 P- Pending
 T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Oncology ABT-510	C	<ul style="list-style-type: none"> • Pursue proof of concept • Leverage TAP knowledge of angiogenesis product development (appropriate endpoints) 	• Project team	• As planned
ABT-751	C	<ul style="list-style-type: none"> • Pursue proof of concept • Use echocardiogram to monitor potential cardiotoxicity • Resolve potent drug manufacturing approach 	• Project team	• As planned
ABT-518	Hold/T	<ul style="list-style-type: none"> • Wait for May results from Pfizer (will save ~\$1mill) and re-evaluate • Halt all further expenditure 	• CMC group • Senior management	• May
Rubitecan	P	<ul style="list-style-type: none"> • Significant clinical rework required (funded by partner)- further in-depth review required • Make a proceed decision when 2Q data available 	• J. Leonard	• By May
Theragyn	P	<ul style="list-style-type: none"> • Negative initial scientific perspective - further in-depth review required, e.g., <ul style="list-style-type: none"> - Determine if there is a PoC to support claim - Address GMP issues - Determine best control to demonstrate efficacy • Re-look at partnership contract 	• J. Leonard	• By May
ABT-627	C	<ul style="list-style-type: none"> • Seek alternative funding (e.g., NCI) before starting major trial • If move ahead <ul style="list-style-type: none"> - Determine how to ensure NDA filing in 2004 - Get FDA input since survival not primary endpoint - Harmonize US and EU study design and inputs • Consider partnership (e.g., BI or established oncology player) 	• J. Tyree • J. Leonard, P. Nisen	• By May • ASAP
			• J. Tyree	• By May

CH-228011-076ism/egDC

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Cardiology/ thrombosis				
Darusentan (LU 135252)	Hold/T	<ul style="list-style-type: none"> Continue currently budgeted funding for next 6 months Do not start any new trials (e.g., hypertension planned for May) Consider out-license or swap 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> Ongoing
LU 208075	Hold/T	<ul style="list-style-type: none"> Continue currently budgeted funding for next six months Look at Myogen deal Out-license or swap 	<ul style="list-style-type: none"> J. Tyree Project team J. Tyree 	<ul style="list-style-type: none"> ASAP ongoing
Levosimendan	C	<ul style="list-style-type: none"> Conduct detailed expert panel review for trial design 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> May
PEG-hirudin	P	<ul style="list-style-type: none"> Set up expert panel for commercial assessment (is diabetes an option?) 	<ul style="list-style-type: none"> E. Ogunro 	<ul style="list-style-type: none"> By May
Ancrod	T	<ul style="list-style-type: none"> Identify out-licensing opportunities 	<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> TBD
Urokinase	P	<ul style="list-style-type: none"> Market research required on open cath Match versus tPA in dose-ranging studies to determine efficacy 	<ul style="list-style-type: none"> E. Fiorentino 	<ul style="list-style-type: none"> By May
Pro-urokinase	C	<ul style="list-style-type: none"> Identify opportunities to speed up program 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> TBD
Clivarine	C	<ul style="list-style-type: none"> Assessment by HPD (review previous evaluation and new trial data) Understand finished product manufacturing cost 	<ul style="list-style-type: none"> E. Ogunro B. Dempsey 	<ul style="list-style-type: none"> By May
Rythmol SR	C	<ul style="list-style-type: none"> Continue filing Verify if package is likely approvable Assess commercial attractiveness in a generic market 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> Ongoing

CH-228011-076sm/cgDC

C- Continue
P- Pending
T- Terminate

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
Neuroscience				
ABT 594	P	<ul style="list-style-type: none"> • Await results from ongoing PII trial – probable T • Project team to develop decision criteria for go/no go 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • June/ July
ABT 963	C	<ul style="list-style-type: none"> • Identify a co-development/co-promotion partner (TAP high on list) • Evaluate benefits of the long half life in pain and cancer (including additional physician market research) • Explore cancer prophylaxis and Alzheimer's indications 	<ul style="list-style-type: none"> • J. Tyree • Project team 	<ul style="list-style-type: none"> • TBD
BSF 201640	P	<ul style="list-style-type: none"> • Complete review of all schizophrenia NCEs with expert panel • Complete staffing of internal project team, but halt further expenditure beyond looking at hepatic tox. and QTc • Understand Novartis contract and level of interest 	<ul style="list-style-type: none"> • I. Loew • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
BSF 190555	P	<ul style="list-style-type: none"> • Complete review as above • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • I. Loew 	<ul style="list-style-type: none"> • As above
BSF 74398	C (no cost)	<ul style="list-style-type: none"> • Allow DevCo to continue development • Re-look at relationship with DevCo 	<ul style="list-style-type: none"> • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
Diluadid Oros	Hold/T	<ul style="list-style-type: none"> • Return to ALZA or out-license to other interested partner 	<ul style="list-style-type: none"> • J. Tyree 	<ul style="list-style-type: none"> • TBD
Hydrocodone	C	<ul style="list-style-type: none"> • Assess regulatory pathway • Understand DEA impact on manufacturing 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • By May
Bimoclomol (ABT 822)	P	<ul style="list-style-type: none"> • Await data from ongoing trial in April before deciding whether to continue - probable T • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • April

CH-228011-076jsm/cgDC
C- Continue
P- Pending
T- Terminate

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
Gastro-enterology				
Ganaton	P	<ul style="list-style-type: none"> • Conduct U.S. commercial assessment with TAP • Assess how to position in Europe versus generics and implications for comparative trial • Develop model to assess spend at different termination points 	<ul style="list-style-type: none"> • E. Fiorentino 	<ul style="list-style-type: none"> • By June
TU-199	T	<ul style="list-style-type: none"> • Terminate outside Japan 	<ul style="list-style-type: none"> • Bob Funck 	<ul style="list-style-type: none"> • By May
AU-224	C	<ul style="list-style-type: none"> • Develop and pursue a small PoC trial in humans ASAP (consider niche indication first and leverage Marlene's expertise) • Conduct market research on IBS versus constipation (including pricing) 	<ul style="list-style-type: none"> • Project team • Project team • E. Fiorentino 	<ul style="list-style-type: none"> • Immediate • ASAP
Immunology				
D2E7	C	<ul style="list-style-type: none"> • Conduct intensive product review <ul style="list-style-type: none"> – 2 day meeting with J. Lennard's group (already in process) – ½ day session with senior management group • Important actions include <ul style="list-style-type: none"> – Approach FDA for fast track and compassionate use – Develop strategy for DMARD claim in first submission – Assess need for Enbrel assay to detect HAHAs – Assess delivery device options – Evaluate additional indications (e.g., Psoriasis, Crohns, heart failure) and pediatric program – Profile Celltech product – Assess impact of additional IV program on reimbursement • Develop list of potential marketing partners for quids 	<ul style="list-style-type: none"> • J. Leonard • Various • J. Tyree 	<ul style="list-style-type: none"> • By May • By May

CH-228011-076ism/cgDC

C- Continue
P- Pending
T- Terminate

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
Immunology (continued) Segard	Hold	<ul style="list-style-type: none"> • Continue filing in EU and Canada • Put on hold in US – consider creating a small team in the US to analyse data, propose smaller PII study • Research pricing, marketing and Phase IV plans in Europe • Look at TNF-alpha levels retrospectively to see stratification with IL-6 • Assess manufacturing strategy • Identify potential out-licensing opportunities (Genentech) 	<ul style="list-style-type: none"> • Project team • J. Leonard 	<ul style="list-style-type: none"> • Ongoing
J695	P	<ul style="list-style-type: none"> • Decide on most attractive indications from Abbott and partner perspective • Discuss with partner ways to share the various indications and potential for TNF-alpha combinations • Add commercial person to the project team by this week 	<ul style="list-style-type: none"> • J. Tyree • E. Fiorentino • J. Tyree • Ongoing 	<ul style="list-style-type: none"> • ASAP

CH-228011-076jsm/cgDC

C- Continue
P- Pending
T- Terminate

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
PIV programs				
Clarithromycin	C	• None identified	-	-
Omnicef	C	• None identified	-	-
Kaletra	C	• None identified	-	-
Norvir	C	• None identified	-	-
Meridia	Hold	<ul style="list-style-type: none"> • Conduct commercial assessment for CNS and depression (P&L) • Assess combination therapy with fibrates • Assess outcomes trial design to meet preferred commercial profile; determine payback 	<ul style="list-style-type: none"> • B. Dempsey, J. Arnott, E. Fiorentino • Project team 	<ul style="list-style-type: none"> • ASAP
Uprima	C	<ul style="list-style-type: none"> • Ensure no redundant trials with TAP in Europe 	• Project team	• Ongoing
Trandolapril patch	T	• Halt all activities	• Project team	• Immediate
Trandolapril "Invest" clinical program	P	• Review trial in more detail (reduce complexity and risk)	• E. Fiorentino	• By May
Other trandolapril trials	C	• Continue "Create", "Peace" and "Benedict" trial programs	• Project team	• Ongoing
Fenofibrate	C	• Develop co-formulation ideas with Meridia and statins (including assessment of sales and costs)	• Project team	-
Depakote	C	• None identified	-	-
Gengraf	C	• None identified	-	-

CH-228011-076ism/cgDC

AGENDA



- Update on the development portfolio review
- **Overview of the phase 2 R&D integration plan**
- Update on the financial baseline
- Preliminary synergy opportunities

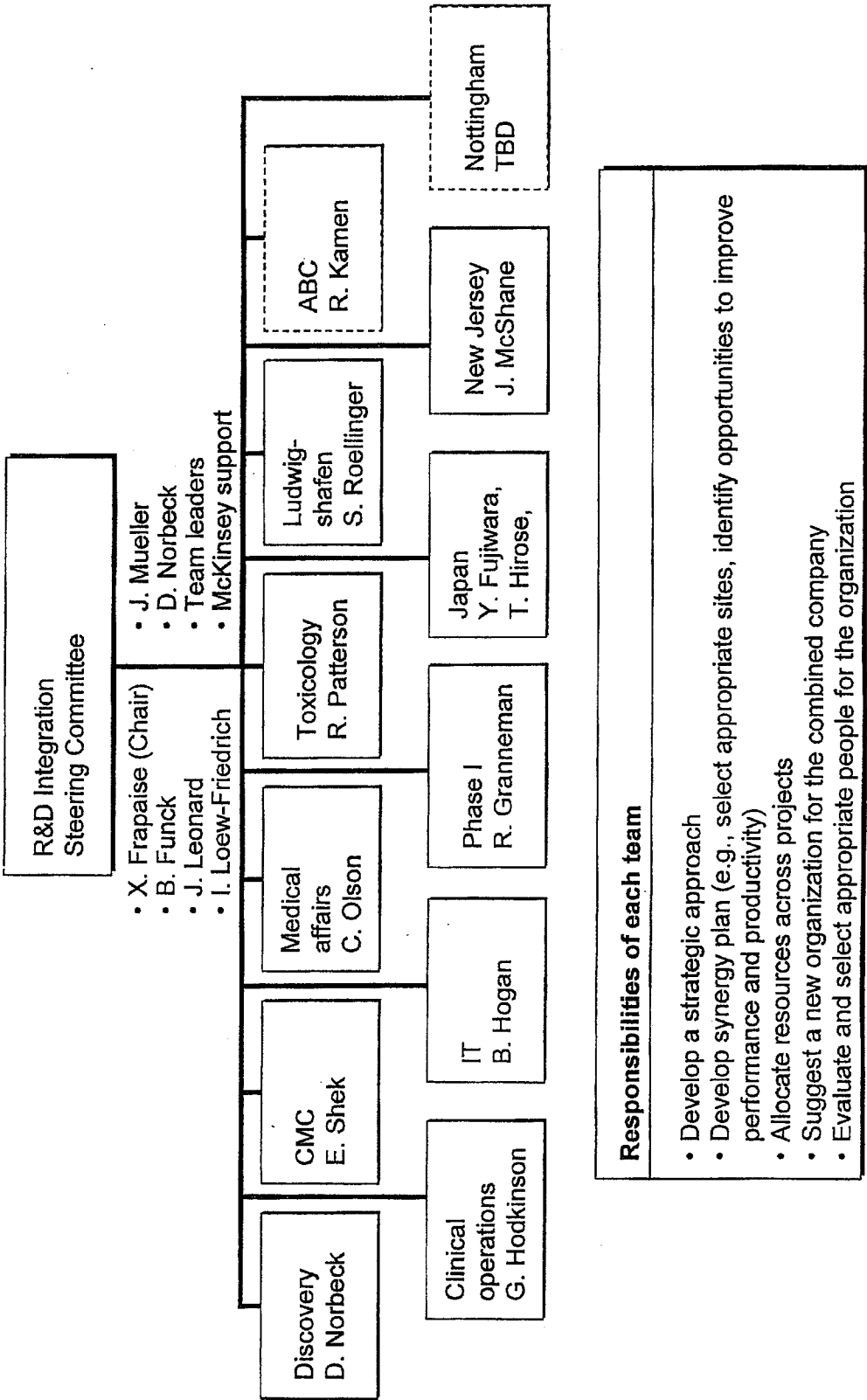
CH-228011-076jsm/cgDC

OVERALL OBJECTIVES

- Our goal is to be the world's premier health care company with a leading, global R&D organization
- To reach that goal, we must take advantage of this unique opportunity to develop an effective long-term strategy and organizational structure
- At the same time, we must balance our long-term objectives against the short-term financial targets that we must meet

CH-228011-076ism/cgDC

REVISED PHASE 2 INTEGRATION TEAMS



CH-228011-076jsm/cgDC

OVERALL SUB-TEAM WORK PLAN

Activity	Timing
1. Launch sub-teams with clear mandates and consistent approach	March 16
2. Develop fact base (x-Knoll, x-Abbott organization structure, activities, headcount, budgets) and initial functional area strategies	March 23
3. Identify initial list of synergy opportunities to improve productivity and performance (structure, processes, purchasing, etc.)	March 28
4. Initial evaluation and prioritization of opportunities	April 2
5. Finalize recommendations and implementation plans for senior R&D management <ul style="list-style-type: none"> - Synergy plan - Organization structure and process improvements - People selection 	April 30
6. Allocate resources across projects after final prioritization is completed	Post-May 8

CH-228011-076jsm/cgDC

DEVELOP THE FACT BASE AND STRATEGY

Mission Why the unit exists

Activities How the unit provides end products

End products What the unit provides to achieve its missions

Strategic objectives Limited number of key objectives for the unit
--

List mission, activities, end products and strategic objectives for the group and subgroup

--

Budget _____ _____ _____ Total \$

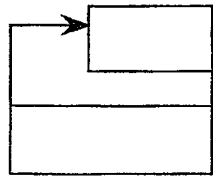
Draw up organization charts and baseline budgets for the group and subgroups

End products _____ \$ _____ \$ _____ \$ _____ \$

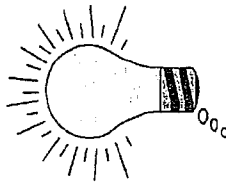
Allocate costs to each product or service (e.g., project-specific costs)

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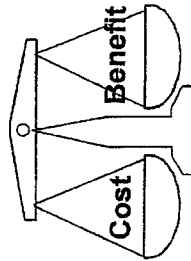
GENERATE AND EVALUATE IDEAS



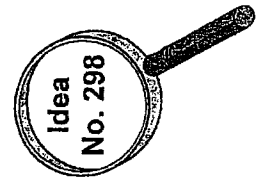
Set "stretch target" to generate ideas (e.g., 15-25%)



Brainstorm ideas to reduce costs and improve service to users



Refine and evaluate each idea to determine cost and benefit

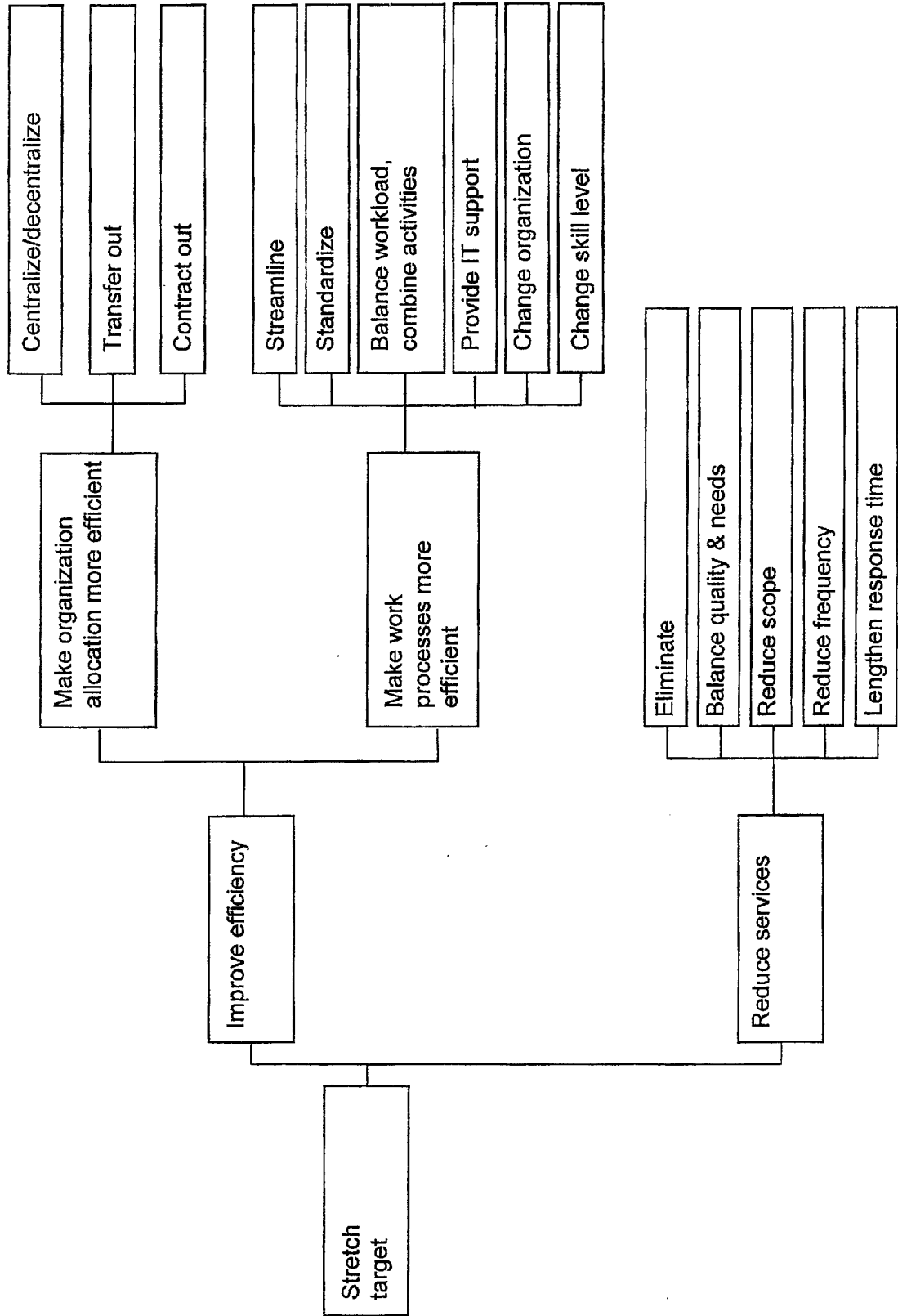


Review each idea with key managers, users, suppliers, and the R&D Steering Committee

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IDEA GENERATION FRAMEWORK

ILLUSTRATIVE



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STATUS OF PHASE 2 INTEGRATION TEAMS

☒ Complete
☐ Partially complete
☐ Not started

Team	1. Launch subteam	2. Develop fact base and strategy	3. Identify synergy opportunities	4. Evaluate/ prioritize opportunities	5. Develop implementation plans
Discovery	n/a	<input checked="" type="radio"/> Review in preparation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clinical operations	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CMC	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IT	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical affairs	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Phase I	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Toxicology	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Japan	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ludwigshafen	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
New Jersey	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ABC	<input type="radio"/>	n/a	n/a	n/a	<input type="radio"/>

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TEAM MANDATE – CLINICAL OPERATIONS & PROJECT MANAGEMENT**Objective**

- To identify high value, short term (2 yr) and long-term process, resourcing and structural opportunities to realize synergies and increase efficiency and effectiveness in the drug development and clinical operations processes. Improvements will focus on Quality, Cost and Speed

Key issues

- Diversity in the way Clinical & Drug Development programs are run: 4 different operating models; at least 60 clinical teams (not including PIV affiliate run programs; and 58 Drug Development teams across the company
- Customer (investigator) satisfaction with Abbott is low (CenterWatch Survey, US and Europe)
- Clinical outsourcing is the norm – 96% of Abbott studies outsourced in 2000 (\$?). Conducted on as needs basis per activity rather than functional or program level (i.e. not strategic)
- Diversity in practices, processes, procedures, documents and systems
- Multiple support groups with differing operating models, processes and requirements
- Lack of ways to share skills, knowledge, information and expertise

End products*Short and long term strategy:*

- Identify preferred operating models for Clinical Operations and Project Management
- Strategic resource plan for clinical operations
- Define opportunities to improve operational efficiency and effectiveness
- Identify which services to consolidate and centralize
- Propose systems for consistent collection, reporting and sharing of project information

Integration plan:

- New project management structure
- New clinical operations structure
- Work plan for achieving synergies

Team members

- Gilliam Hodkinson – Chair
- Tom Woidat – Finance analyst
- Ellis Purcell – clin ops sub-team
- Kathe Balinski – clin ops sub-team
- Mathias Luz – clin ops sub-team
- Jerry Osbourne – project management sub-team
- Leticia Delgado-Herrera – project management sub-team
- Eddie Chong – project management sub-team
- Rick Granneman – DM/Stats sub-team
- Jennifer Manski – project management sub-team
- Doane Chilcoat – McKinsey

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CMC TEAM MANDATE

Objective <ul style="list-style-type: none"> • Develop CMC processes leading to a strategic approach • Develop synergy plan (e.g., select appropriate sites, identify opportunities to improve performance and productivity) • Suggest a new organization for the combined company • Evaluate and select appropriate people for the organization 	
End products	Key issues <ul style="list-style-type: none"> • Scope of CMC R&D responsibilities • Contract out vs. internal activities • Location (proximity to R&D, Manufacturing • Facilities (how many, where) • Pilot plants (how many, size, location) • Organization (functional, size) • Performance and productivity improvements • Potent drug strategy • Drug delivery capabilities

Team members

- Efraim Shek – Chair
- Steve Szostak, Karen Session – Finance analyst
- Kathy McFarland, Fritz Richter, Jim Mitchell, John McShane
- Doane Chicoat – McKinsey

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TEAM MANDATE – TOXICOLOGY AND RELATED SCIENCESEXAMPLE**Objective**

- Develop an integration plan that reduces costs, improves efficiencies and eliminates redundancies
- Develop a strategy to implement the plan over time using all resources optimally

Key issues

1. Degree of centralization of scientific capabilities and strategies to achieve goals
2. Balance of demands with capacities
3. Elimination of unnecessary activities
4. Strategic balance of internal and external resourcing

End products

1. Reduced duplication of facilities, personnel, capital investment over time
2. Reduce any underabsorption with CRO work and overabsorption with dispersion of tasks to underutilized areas
3. Reduction of activities not essential to the development process, to redirect toward more vital activities or eliminate
4. Devise a strategy to increase CRO use in areas where cost effective and reduce in areas where premium paid

Team members

- Reid Patterson – Chair
- Tom Woidat – Finance analyst
- 6 DSE Directors
- Fritz Richter, Global Head Pharm Ctrs
- Ray Dorsey – McKinsey

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TEAM MANDATE – PHASE IEXAMPLE

<p>Objective</p> <ul style="list-style-type: none"> • Determine appropriate scope and level of services to be provided • Design optimal structure and staff for Phase 1 (Clinical Pharmacology) group • Identify opportunities for improvement within the group 	<p>Key issues</p> <ul style="list-style-type: none"> • Extent of global responsibilities for Clin Pharm group • Integration of Statistics and Clin Pharm activities into drug development now and in the future • Services to be provided internally vs. externally • Appropriate number of Phase I units 	<p>End products</p> <ul style="list-style-type: none"> • Optimal organizational structure and staff for the group • Assessment of value of a European Clin Pharm service to venture heads • List of services and activities to be provided by the group • Set of group opportunities for improvement including financial impact and implications • Assessment and recommendation of viability of Phase I units based on several factors (e.g., capabilities, cost-effectiveness, capacity, future investments requested)
<p>Team members</p> <ul style="list-style-type: none"> • Rick Granneman – Chair • Kay Rekau – Finance analyst 	<ul style="list-style-type: none"> • Walid Awani, Bob O'Dea, Laura Williams, Carl Mendel (MO), Mike Rubison • Ray Dorsey – McKinsey 	

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AGENDA

- Update on the development portfolio review
- Overview of the phase 2 R&D integration plan
- **Update on the financial baseline**
- Preliminary synergy opportunities



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Knoll Integration Finance Action Items

Progress on the R&D Baseline

- Obtained 2001/2002 Knoll Plan by Program by Location.
- Sent out detailed finance data request for all Knoll sites to validate 2001 Plan, provide functional expense detail, plus adjust for March 2 close date. Information expected back 03/23.
- Assigned finance support to each R&D integration sub-team to manage financial baseline data and value synergy opportunities.

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Knoll Integration Finance Action Items

Next Steps to Finalize Baseline by April 2

- Update Abbott 2001 Plan Budgets via April Update Reviews.
- Line up x-Knoll and Abbott budgets by functional area.
- Consolidate into a single base line budget for 2001 (will change post May 8th with new portfolio priorities and sub-team generated synergies).
- Complete assessment of differences between the x-Knoll budget and the acquisition model (including budget shifts due to definitional changes).
- Finalize Hancock funding impact.
- Finalize Meridia outcome study cost/accounting treatment.
- Prepare cost estimate for New Jersey satellite office.

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**Knoll Integration
Finance Action Items**

Items Not Considered in Baseline Spend

- International Affiliate Medical/Regulatory Affairs.
- International Phase IIIb/IV expense.
- International local R&D spend.
- HPD R&D (other than Abbott R&D reorg).

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AGENDA

- Update on the development portfolio review
- Overview of the phase 2 R&D integration plan
- Update on the financial baseline
- Preliminary synergy opportunities



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PRELIMINARY SYNERGY OPPORTUNITIESPRELIMINARY

	Opportunity	Estimated cost savings
Clinical operations	<ul style="list-style-type: none"> • Use strategic outsourcing best practices across clinical programs (e.g., use 1 vendor for 1 drug program to realize efficiency savings) <ul style="list-style-type: none"> – Recently changed budgeted plans for ABT-627 Pill program, placing 2 studies with a single CRO • Use of Abbott Preferred providers for all Knoll Phase II-IV clinical service outsourcing 	<ul style="list-style-type: none"> • Significant incremental volume discount (e.g., 10-15%) <ul style="list-style-type: none"> – ABT-627 example will realize \$6.2mill in savings over 4 years • Up to 10% on Knoll preferred provider spend
Phase I	<ul style="list-style-type: none"> • Assess and rationalize Phase I units and CRO spend. Currently, two Phase I units are in operation (one in Ludwigshafen and one in Waukegan) and extensive outsourcing also conducted. 	<ul style="list-style-type: none"> • TBD

Source: Sub-teams

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PRELIMINARY SYNERGY OPPORTUNITIES (CONTINUED)PRELIMINARY

Information technology	Opportunity	Estimated cost savings
	<ul style="list-style-type: none"> Disentangle R&D IT support from BASF corporate support Currently BASF is charging \$4 million/month for IT services to all of the former BASF Pharma. Significant overhead embedded within this arrangement 	<ul style="list-style-type: none"> ~\$1-2 million in 2001 \$2-4 million(annual) thereafter* (for R&D)
	<ul style="list-style-type: none"> Identify and stop work on redundant R&D IT projects Main contributor is the overlap of BASF Pharma Emerging Dossier project with Abbott e-submissions program 	<ul style="list-style-type: none"> \$1-2 million in 2001 \$1-2 million in 2002
	<ul style="list-style-type: none"> Enforce BASF indemnification for R&D software licenses. Abbott entitled to this under the Amendment to the Purchase Agreement. 	<ul style="list-style-type: none"> ~\$3-4 million in cost avoidance for 2001 only

* Additional investment may be required to achieve the savings. These savings may have been "counted" by the IT integration team
Source: IT sub-team

DEPOSITION EXHIBIT 8

PLT'S EXHIBIT FL

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Overview of Abbott R&D



Fact Pack
April 2001

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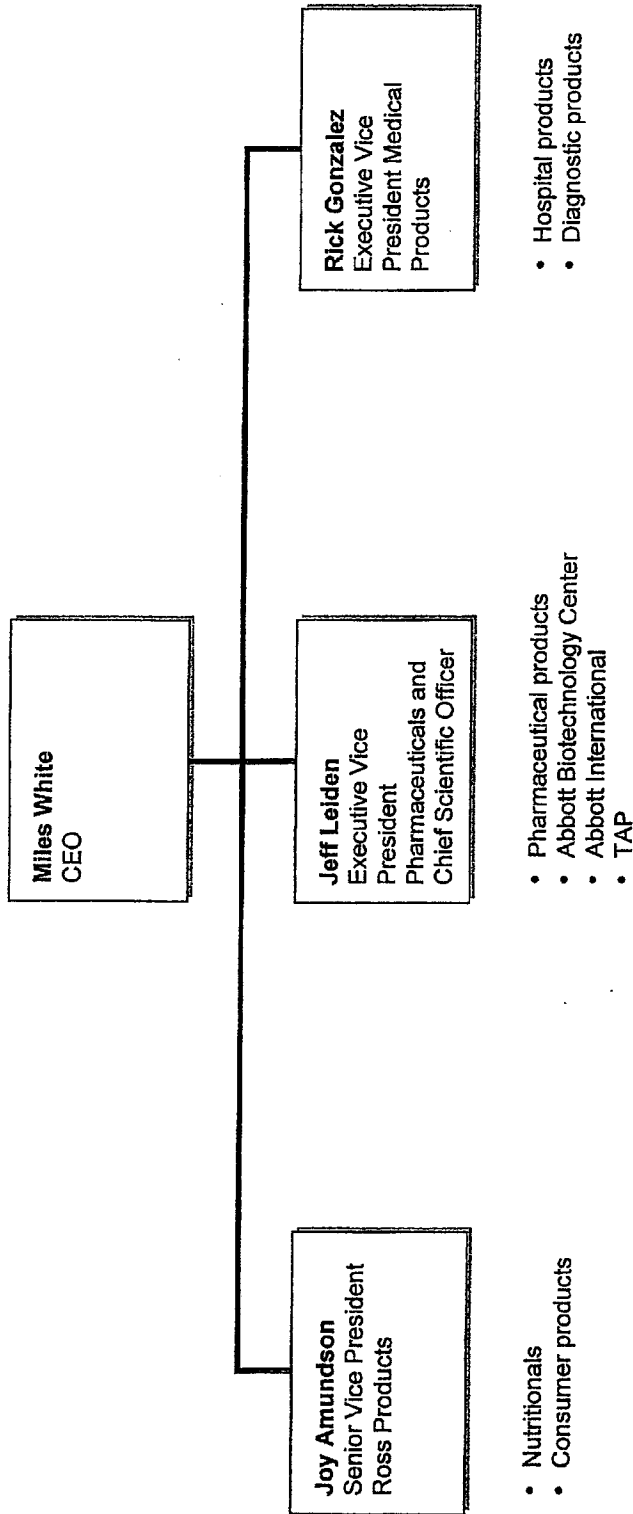


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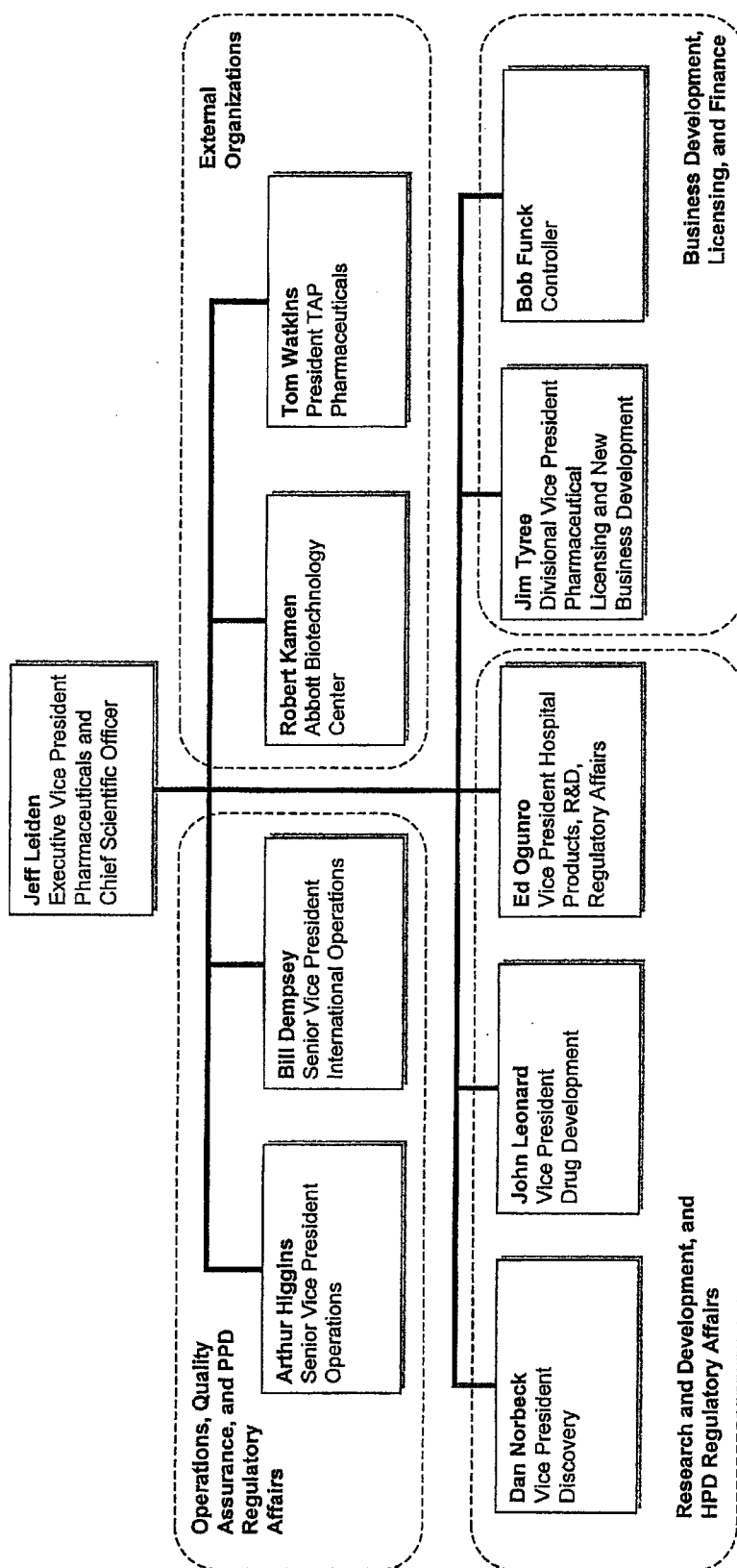
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ABBOTT LABORATORIES ORGANIZATION

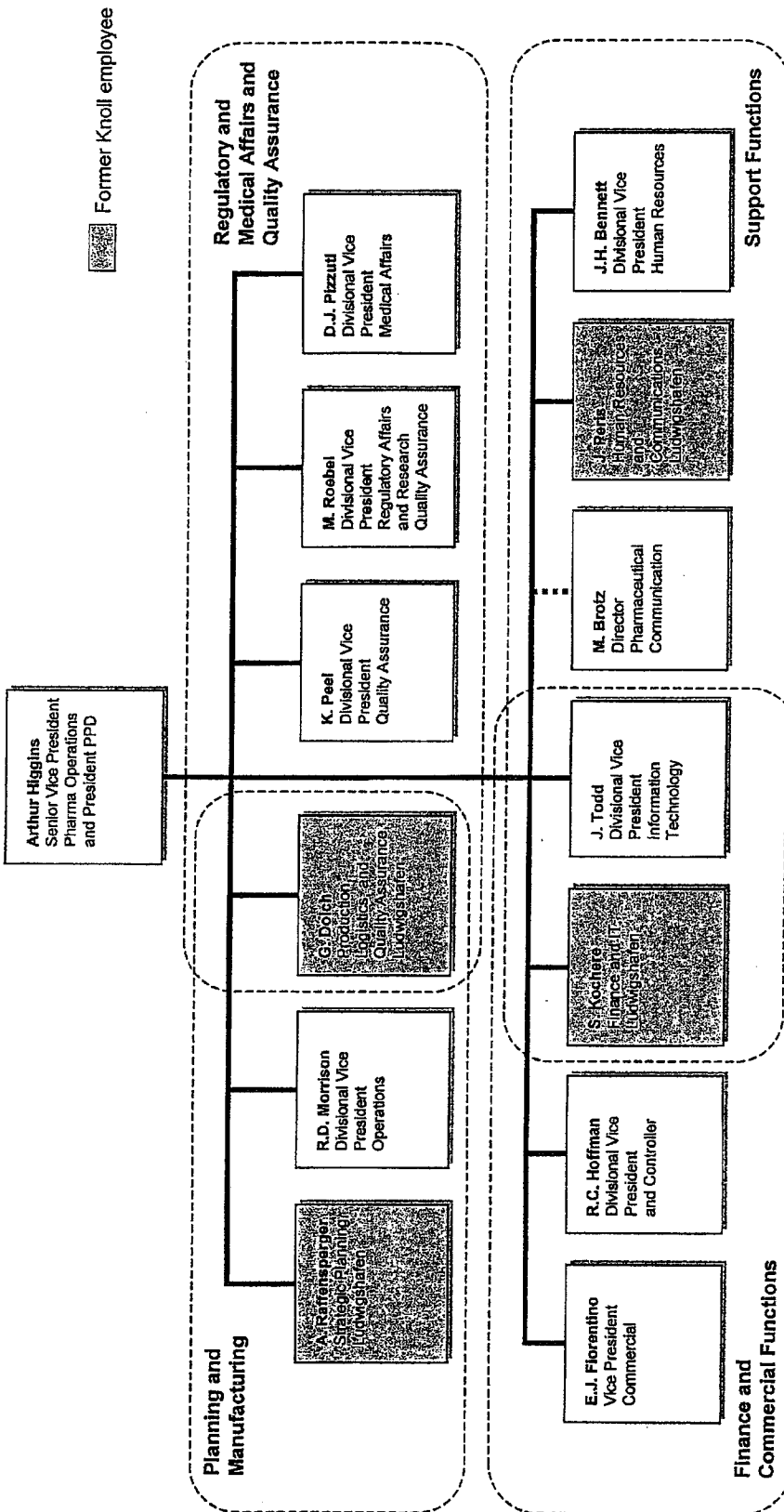
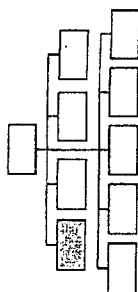


GLOBAL PHARMACEUTICAL ORGANIZATION



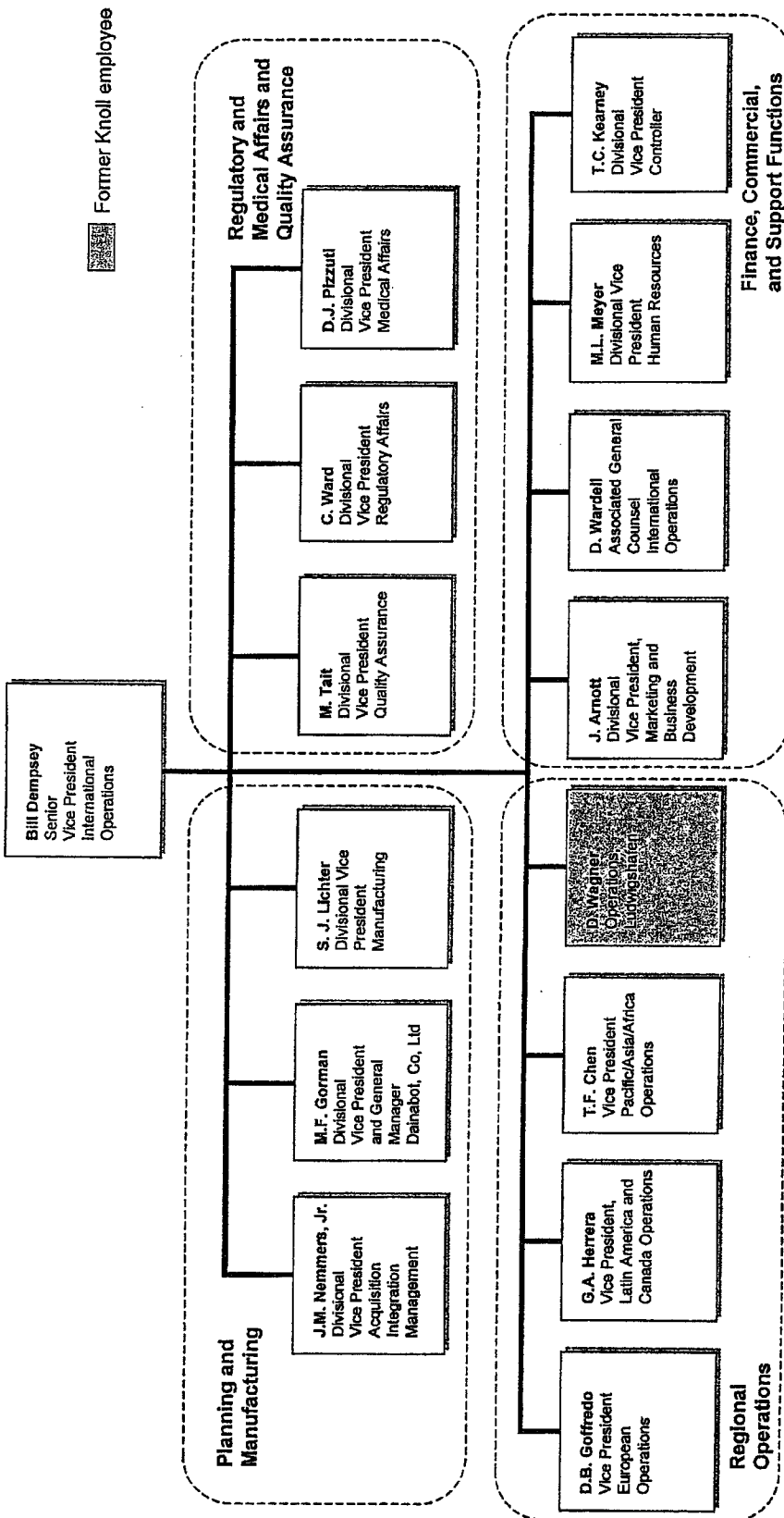
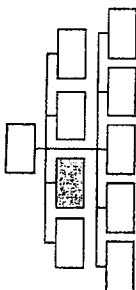
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PHARMACEUTICAL OPERATIONS ORGANIZATION



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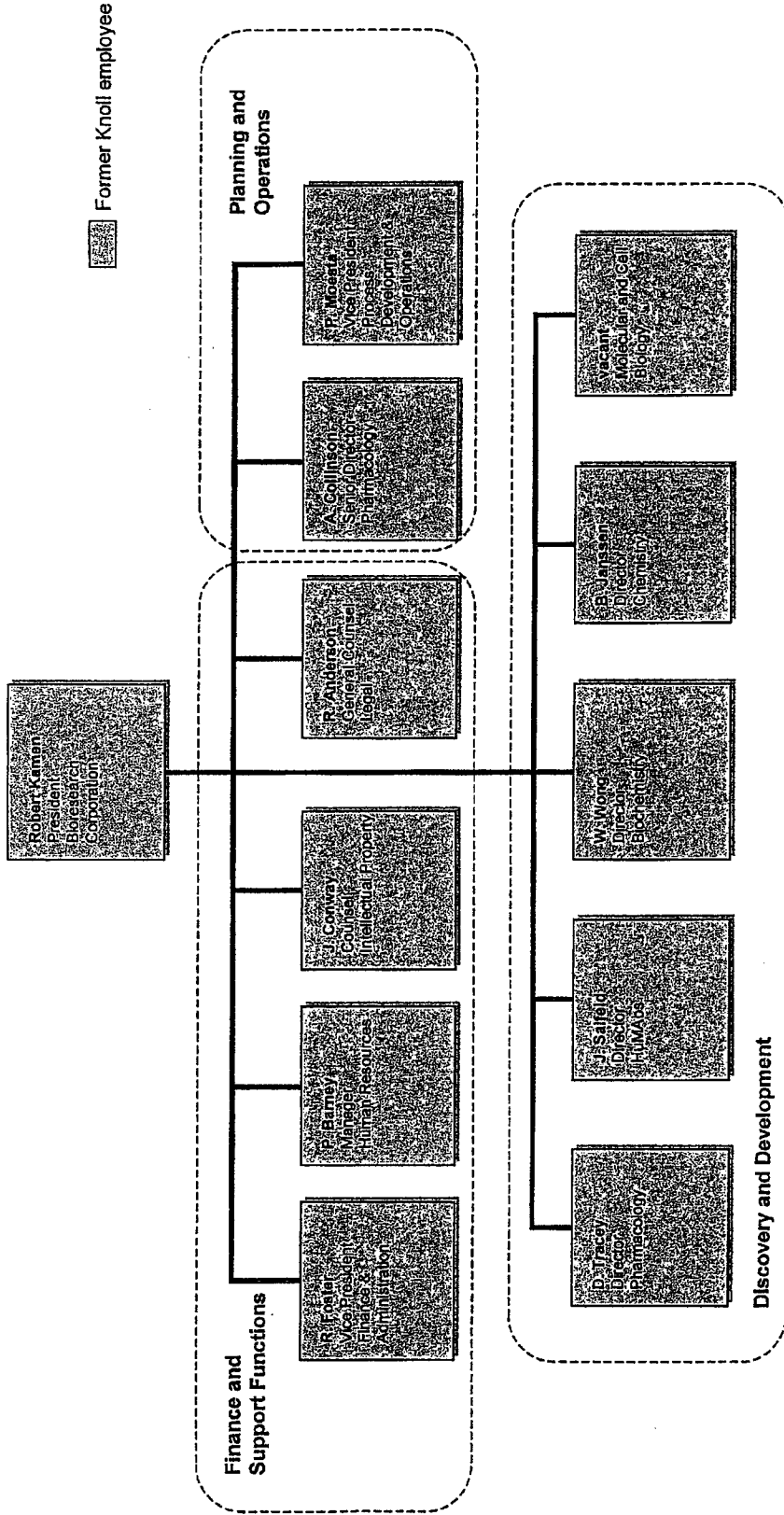
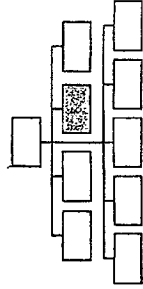
INTERNATIONAL PHARMACEUTICAL OPERATIONS ORGANIZATION



Former Knoll employee

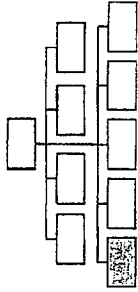
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ABBOTT BIOTECHNOLOGY CENTER ORGANIZATION

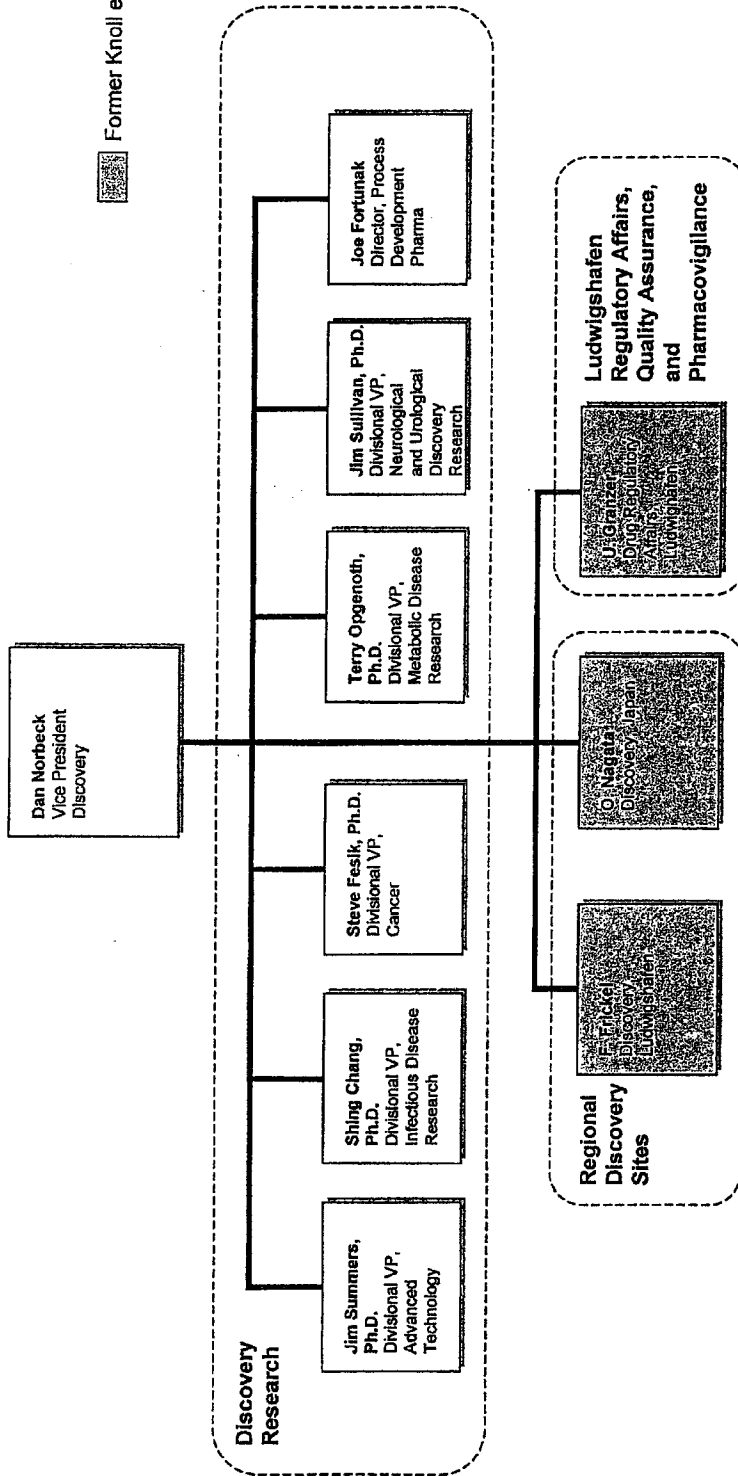


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GLOBAL PHARMACEUTICAL DRUG DISCOVERY ORGANIZATION

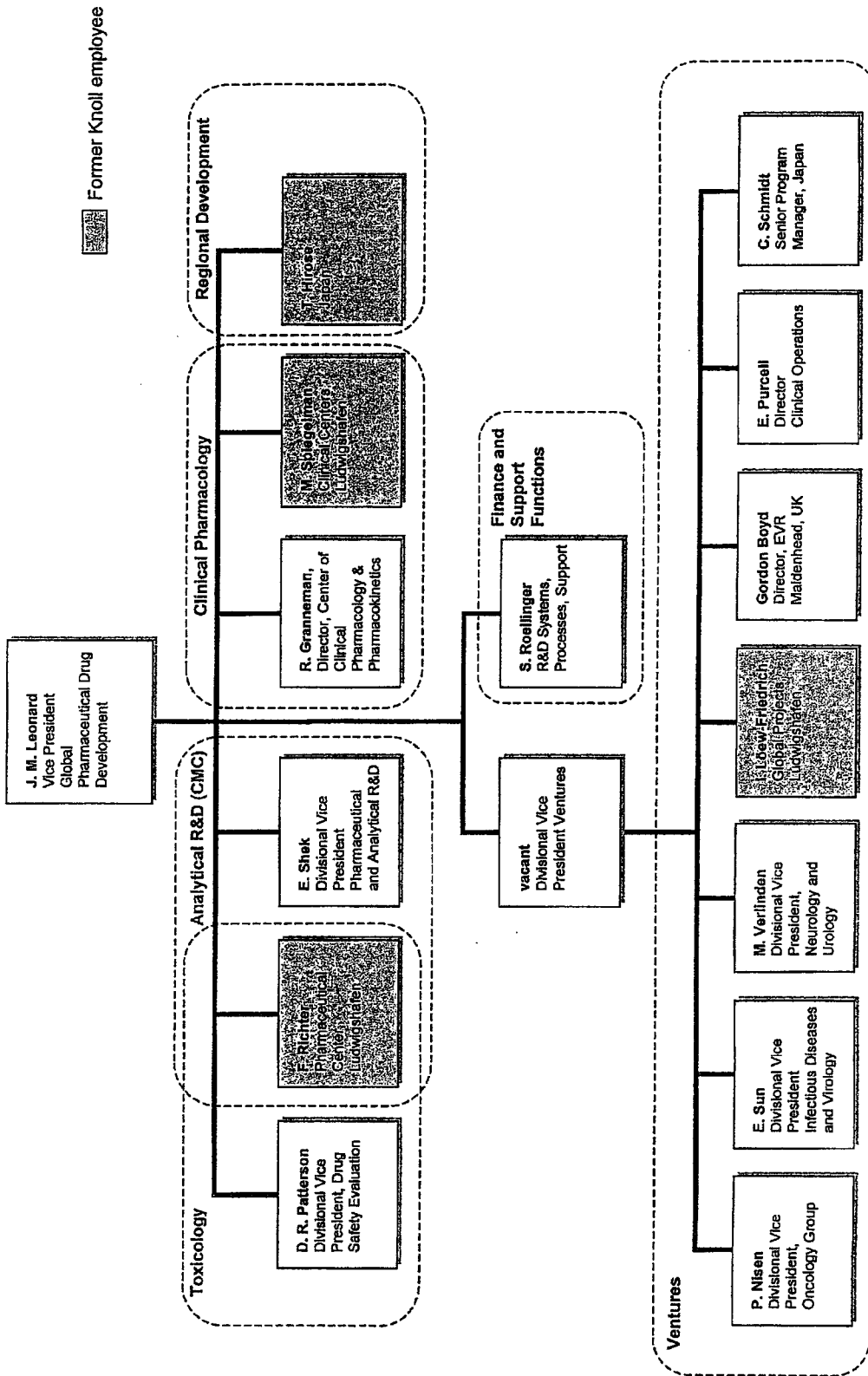
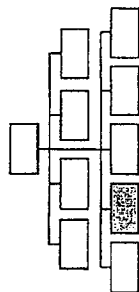


Former Knoll employee



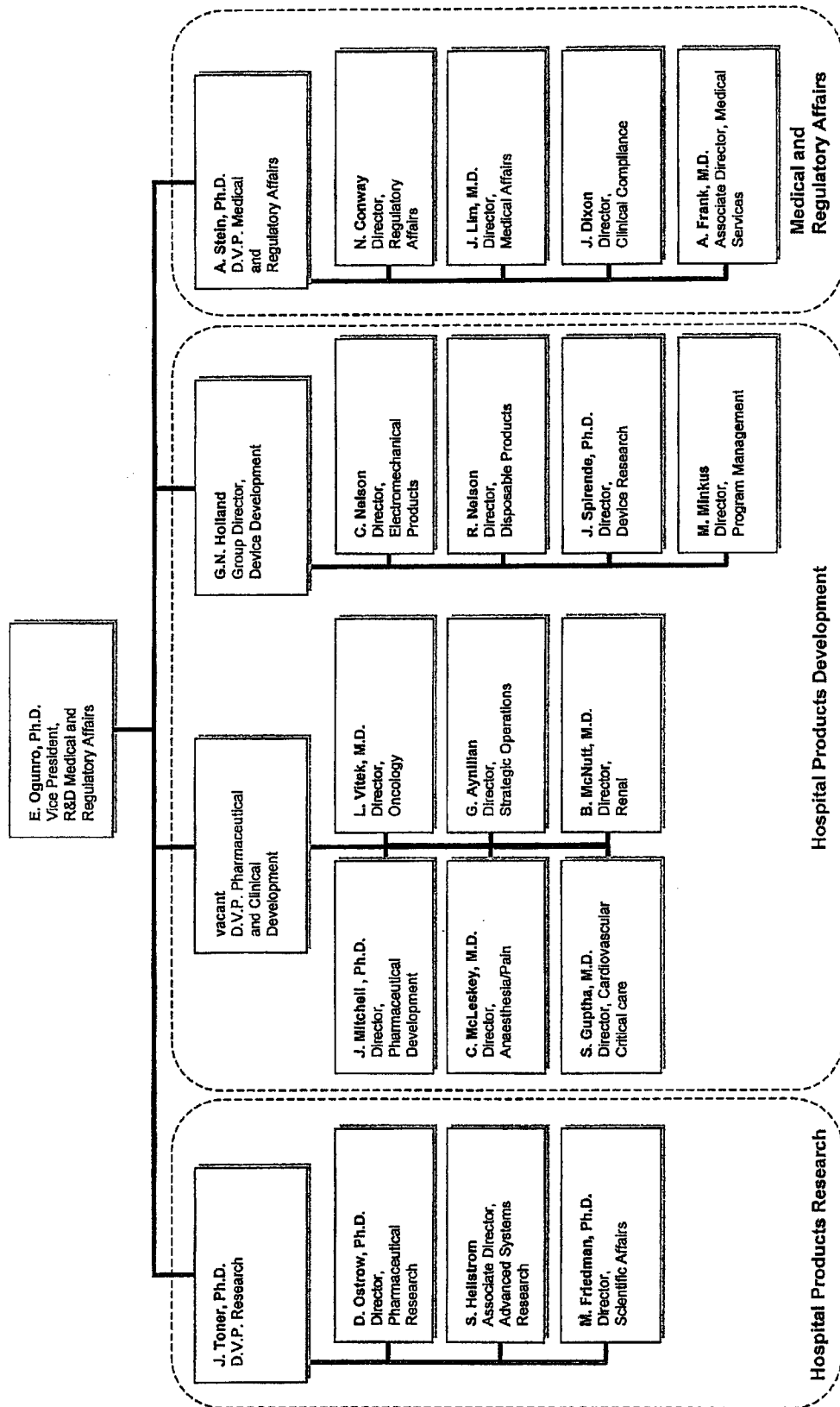
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GLOBAL PHARMACEUTICAL DRUG DEVELOPMENT ORGANIZATION



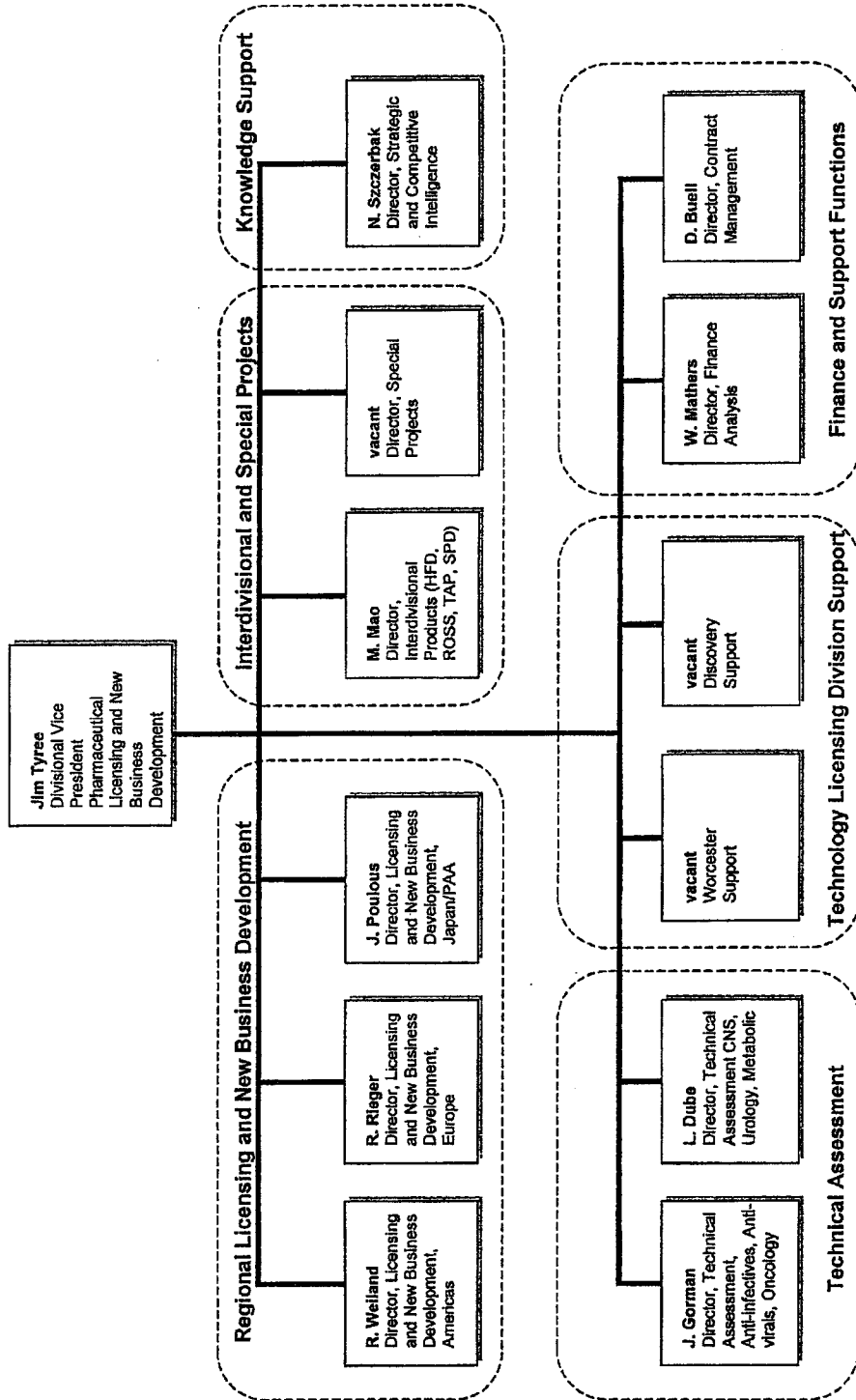
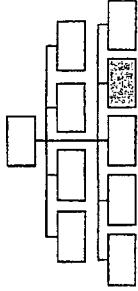
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HOSPITAL PRODUCTS DIVISION R&D AND MEDICAL AND REGULATORY AFFAIRS ORGANIZATION



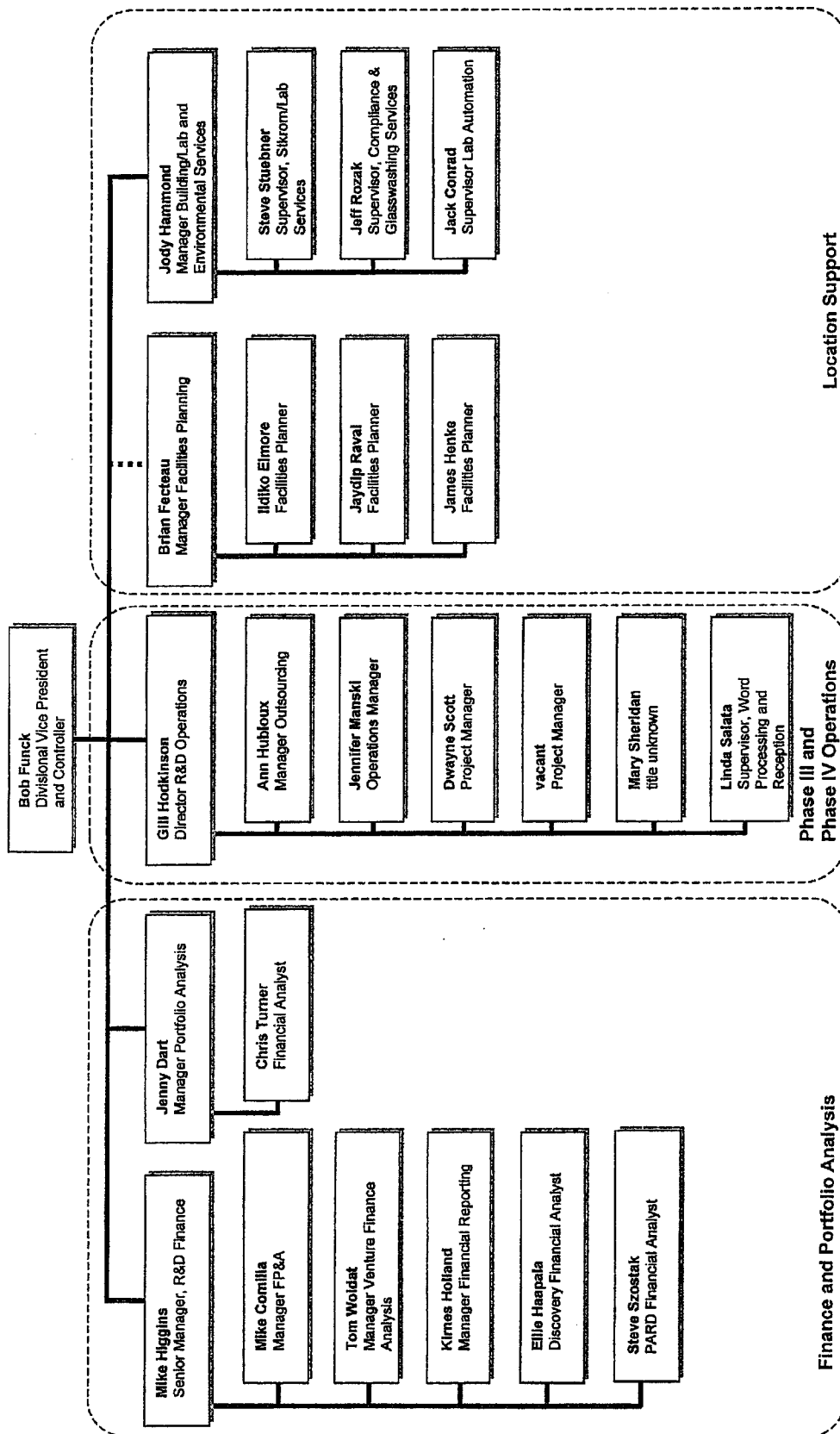
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GLOBAL PHARMACEUTICAL LICENSING AND NEW BUSINESS DEVELOPMENT




```

graph TD
    L[L] --- L1[L1]
    L --- L2[L2]
    L2 --- L21[L21]
    L2 --- L22[L22]
    
```



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2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5
Abbott International R&D	28.0
Hospital Products R&D	2.3
Recent additions to GPD subtotal	62.1
Abbott Discovery	192.0
Abbott Development	380.0
Abbott subtotal	572.0
TAP & Sister Division	57.0
Abbott total	629.0
x-Knoll Corp. Discovery	130.3
x-Knoll Corp. Development	258.3
x-Knoll other corporate	-30.5
x-Knoll local R&D	18.0
x-Knoll other*	34.0
x-Knoll total	410.0
R&D total	1,100.9

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

Note: x-Knoll data is preliminary

Source: R&D Finance

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2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5	<div> <ul style="list-style-type: none"> • NC Chemistry • Chemical Development • Special Labs </div>
Abbott International R&D	28.0	
Hospital Products R&D	2.3	
Recent additions to GPD subtotal	62.1	
Abbott Discovery	192.0	
Abbott Development	380.0	
Abbott subtotal	572.0	
TAP & Sister Division	57.0	
Abbott total	629.0	
x-Knoll Corp. Discovery	130.3	
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* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

** International development center

Note: x-Knoll data is preliminary

Source: R&D Finance

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2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5	<div> <ul style="list-style-type: none"> • IDC** 7.7 • Other 23.8 Total 31.5 </div>
Abbott International R&D	28.0	
Hospital Products R&D	2.3	
Recent additions to GPD subtotal	62.1	
Abbott Discovery	192.0	
Abbott Development	380.0	
Abbott subtotal	572.0	
TAP & Sister Division	57.0	
Abbott total	629.0	
x-Knoll Corp. Discovery	130.3	
x-Knoll Corp. Development	258.3	
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x-Knoll total	410.0	
R&D total	1,100.9	

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

** International development center

Note: x-Knoll data is preliminary

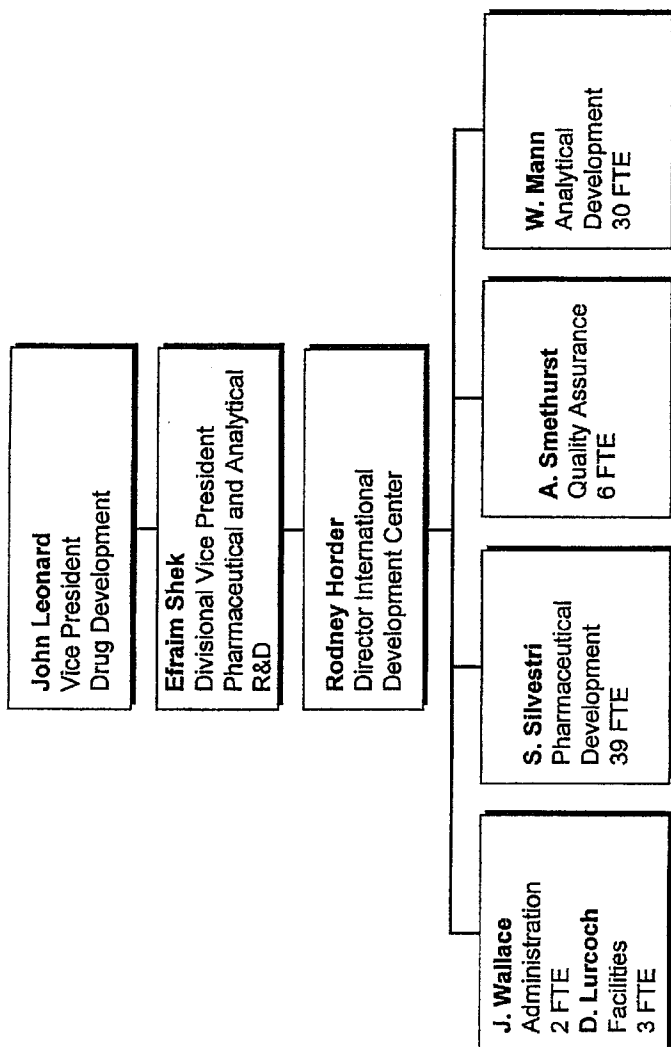
Source: R&D Finance

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ABBOTT INTERNATIONAL R&D OVERVIEW

\$ Millions

	<u>Budget</u>	<u>Headcount</u>
IDC	7.7	79
Others	23.8	?
Total	31.5	?

IDC structure**IDC activities**

Formulation development, historically to support Abbott International

IDC budget

Payroll	3.2
Employee related	0.9
Operating	1.6
Fixed	2.0
Total	7.7

Service sold – AI	3.5
Service sold – PPD	3.0
Service sold – other	0.7 (internal costs)

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2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5	
Abbott International R&D	28.0	
Hospital Products R&D	2.3	
Recent additions to GPD subtotal	62.1	Oncology venture
Abbott Discovery	192.0	
Abbott Development	380.0	
Abbott subtotal	572.0	
TAP & Sister Division	57.0	
Abbott total	629.0	
x-Knoll Corp. Discovery	130.3	
x-Knoll Corp. Development	258.3	
x-Knoll other corporate	-30.5	
x-Knoll local R&D	18.0	
x-Knoll other*	34.0	
x-Knoll total	410.0	
R&D total	1,100.9	

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

Note: x-Knoll data is preliminary

Source: R&D Finance

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2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5
Abbott International R&D	28.0
Hospital Products R&D	2.3
Recent additions to GPD subtotal	62.1

Abbott Discovery	192.0
Abbott Development	380.0
Abbott subtotal	572.0

TAP & Sister Division	57.0
Abbott total	629.0

x-Knoll Corp. Discovery	130.3
x-Knoll Corp. Development	258.3
x-Knoll other corporate	-30.5
x-Knoll local R&D	18.0
x-Knoll other*	34.0

x-Knoll total	410.0
R&D total	1,100.9

770 headcount	
Cancer	43.0
Infectious Disease	35.4
Metabolic Disease	26.5
Neurological	41.6
Other	45.5
Total	192.0

"Other" includes research in other TAs

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

Note: x-Knoll data is preliminary

Source: R&D Finance

2001 ABBOTT DISCOVERY BUDGET OVERVIEW

\$ Millions

Cancer	43.0
Infectious Disease	35.4
Metabolic Disease	26.5
Neurological	41.6
Other	45.5
Total	192.0

770 headcount

Discovery	6,889
• Matrix Metalloproteinase	5,157
• Urokinase	9,688
• Angiogenesis	8,975
• Apoptosis	7,783
• Farnesyltransferase	1,487
• Anti-Mitotic	0,154
• Chemotherapeutics	1,129
• Cancer Exploration Biology	3,685
• Cancer Research Misc.	42,947
Total Cancer Research	13,089
• Anti-Viral Research	13,196
• Anti-Bacterial Chemistry	8,320
• Novel Anti-Bacterial	(1,850)
• Microbiology Research	2,434
• Infective Dis Research Misc	35,399
Total Infectious Disease	7,900
• Diabetes: Cell Biology	7,948
• Diabetes: Signal Transduction	0,845
• Kara Bio	0
• Growth Factors	0
• Cell Adhesion	4,080
• New Targets	5,785
• Metabolic Diseases Misc	28,688
Total Metabolic Disease	7,825
• Cholinergic Modulation	4,557
• Urological Diseases	7,286
• Exploratory Urology	4,897
• Pulmonary Research	2,468
• CNS Disease Research	0,977
• NUDR Chemistry	6,888
• Neurology & Urology Misc	41,883
Total Neurological	4,650
• Structural Biology	1,954
• Structural Chemistry	4,154
• Genomics	0,468
• CAMD	0,770
• Molecular Services	2,178
• Automation/Engineering	8,240
• Combinatorial Chemistry	3,954
• Biological Screening	0
• Patent Liaison Services	1,835
• Advanced Technology Misc	28,903
Total Advanced Technology	3,748
• Process Chemistry	0,461
• Process Research	1,386
• Chemical Sciences Misc	5,595
Total Chemical Science	0,361
• Ligand	0
• Immunosuppressants	2,581
• Integrative Pharmacology	1,008
• Integrative Pharm Admin	3,938
Total Inte Pharmacology	12,040
• Discovery Support	(4,173)
• Other/ODC	0
• Absorption/Discretionary	7,867
Total Other	192,000
Total	

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2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D 31.5
 Abbott International R&D 28.0
 Hospital Products R&D 2.3

Recent additions to GPD subtotal 62.1

Abbott Discovery 192.0
 Abbott Development 380.0

Abbott subtotal 572.0

TAP & Sister Division 57.0

Abbott total 629.0

x-Knoll Corp. Discovery 130.3

x-Knoll Corp. Development 258.3

x-Knoll other corporate -30.5

x-Knoll local R&D 18.0

x-Knoll other* 34.0

x-Knoll total 410.0**R&D total 1,100.9**

770 headcount	Administrative overhead	36,728
	Functional	151,593
	Internal services sold	-
	External services sold	(13,420)
	Drug Safety - Metabolism	6,515
	Drug Safety - Toxicology/Pathology	2,523
	Drug Safety - Comparative medicine	7,969
	Drug Safety - Strategic and Exploratory	468
	Phase I Center Clinical	304
	Development Operations - Biostatistics	98
	Development Operations - Research	32
	Information Center	
	Information Management and Technology	1,946
	International Manpower	153
	PARC	2,198
	Research QA	3
	Investigational Drug QA	1
	SPD	2,621
	Absorption/Discretionary	(7,732)
	Total	192,000

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

Note: x-Knoll data is preliminary

Source: R&D Finance

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2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5
Abbott International R&D	28.0
Hospital Products R&D	2.3
Recent additions to GPD subtotal	62.1
Abbott Discovery	192.0
Abbott Development	380.0
Abbott subtotal	572.0
TAP & Sister Division	57.0
Abbott total	629.0
x-Knoll Corp. Discovery	130.3
x-Knoll Corp. Development	258.3
x-Knoll other corporate	-30.5
x-Knoll local R&D	18.0
x-Knoll other*	34.0
x-Knoll total	410.0
R&D total	1,100.9

1,613 headcount

Neuroscience	40.6
• Depakote	24.1
• Gabitril	1.4
• ABT-594 (CCM)	9.3
• COX-II (ABT-963)	1.2
• ABT-089 (ChCM)	0.6
• RP-Schere/Alza (Hydrocodone)	4.0
Anti Infective	132.3
• Clarithromycin (Blaxin XL)	14.9
• Ketolide (ABT-773)	88.0
• Quinolone (ABT-492)	24.5
• Omnicef	4.9
Urology/cardiology	8.7
• BPH backup (ABT-980)	2.3
• Fenofibrate (Fournier)	1.4
• KCO (potassium channel: ABT-598)	5.0
HIV	57.5
• Ritonavir (Norvir)	4.0
• Kaletra	51.0
• Cyclosporine (Gengraf)	2.5
Cancer	64.6
• Endothelin (ABT-627)	38.8
• TSP No. 1 (ABT-510)	10.0
• Metalloproteinase (ABT-518)	7.4
• Anti-Mitotic (ABT-751)	8.4
Other	42.1
• Misc. R&D**	8.2
• Non-promotional products	11.1
• SPD process	14.2
• SPD excess capacity	11.6
• CRO rebates	(3.0)
Absorption	44.0
• Discovery	4.0
• Drug safety	9.1
• Medical Affairs	1.6
• IM&T	0.6
• Development Ops	4.2
• PARO	7.2
• Reg. Affairs/QA	(0.2)
• Phase I	1.0
• Fixed EVR	2.0
• Overhead burden	4.7
• Misc. fixed	5.0
• Internal	4.8
Affordability	(9.8)
Total Abbott Development	380.0

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"
 ** Includes unallocated floor space/depreciation, etc.

Note: x-Knoll data is preliminary

Source: R&D Finance

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2001 ABBOTT DEVELOPMENT EXTERNAL/INTERNAL**\$ Millions**

	External				Total Internal	2001 plan targets
	Grants	SPD materials	PARD material	A.I. grants	Total external	
Neurology						
• Depakote	9.4	-	0.6	-	10.0	24.1
• Gabitril	-	-	-	-	-	1.4
• ABT-594 (formerly CCM)	1.1	-	0.2	-	1.3	9.3
• COX-II	0.1	-	-	-	0.1	1.2
• ABT-089 (formerly ChCM)	-	-	-	-	-	0.6
• RP Scherer/Alza (Hydrocodone)	-	-	-	-	-	4.0
Subtotal Neurology	10.6	-	0.8	-	11.4	40.6
Anti-infective						
• Clarithromycin	2.9	0.3	0.3	8.5	12.0	14.9
• Ketolide	47.4	4.7	1.0	1.7	54.8	88.0
• Quinolone	5.0	1.9	-	0.2	7.1	24.5
• Ornicef	3.0	-	-	-	3.0	4.9
Subtotal Anti-Infective	58.3	6.9	1.3	10.4	76.9	132.3
Urology/cardiology						
• BPH backup	-	-	-	-	-	2.3
• Fenofibrate (Fournier)	-	-	-	-	-	1.4
• KCO	0.4	-	-	-	0.4	5.0
Subtotal Urology/cardiology	0.4	-	-	-	0.4	8.7
HIV						
• Ritonavir	1.2	-	-	0.7	1.9	4.0
• Kaletra	22.6	-	1.5	0.2	24.3	51.0
• Cyclosporine	1.0	-	-	0.2	1.2	2.5
Subtotal HIV	24.8	-	1.5	1.1	27.4	57.5
Cancer						
• Endothelin	19.3	-	0.6	-	19.9	38.8
• TSP #1	1.6	0.5	0.2	-	2.3	10.0
• Metalloproteinase	1.1	-	-	-	1.1	7.4
• Anti-Mitotic	1.1	0.3	0.1	0.3	1.6	8.4
Subtotal cancer	23.1	0.8	0.9	0.3	25.1	54.6
Other						
• Affordability	0.8	-	-	-	0.8	86.1
Total development	118.0	7.7	4.5	11.8	142.0	380.0
Discovery						
	-	-	-	0.1	-	192.0
Total	118.0	7.7	4.5	11.9	142.0	572.0

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2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5
Abbott International R&D	28.0
Hospital Products R&D	2.3
Recent additions to GPD subtotal	62.1
Abbott Discovery	192.0
Abbott Development	380.0
Abbott subtotal	572.0
TAP & Sister Division	57.0
Abbott total	629.0
x-Knoll Corp. Discovery	130.3
x-Knoll Corp. Development	258.3
x-Knoll other corporate	-30.5
x-Knoll local R&D	18.0
x-Knoll other*	34.0
x-Knoll total	410.0
R&D total	1,100.9

2,283
headcount

Pharmaceutical Discovery	153.0
Drug Safety	39.0
Medical Affairs	19.0
Information Management & Technology	50.0
Development Operations	17.0
Venture Management	34.0
Administration	20.0
Pharmaceutical Analytical Research & Development	59.0
Regulatory Affairs/Quality Assurance	9.0
Phase I Center	10.0
Functional Subtotal	410.0
Clinical Grants	118.0
Services purchased*	47.0
SPD services purchased	53.0
Other	0.4
Total	629.0

* About \$40 million from within Abbott (e.g., legal)

Note: x-Knoll data is preliminary

Source: R&D Finance

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ABBOTT DISCOVERY AND DEVELOPMENT FUNCTIONAL GROUPS

Function	2001 budget (\$ Millions)	Headcount	Leader	Description
Pharmaceutical discovery	153	770	Dan Norbeck, VP	Conducts research activities that lead to development of selected products
Drug safety	39	189	Reid Patterson, DVP	Chemists and biologists researching drug absorption, metabolism, damage, etc.
Medical Affairs	19	137	Dave Pizzuti, DVP	Continued development of PPD marketed products, including formulation development, label expansion, and market driven. Also post-marketing safety
Information management and technology	50	257	Bob Hogan	IT resource management, training, and support. Maintains system, develops customer applications
Development operations	17	181	Mike Rubison*, Group Director	Supports development of databases, report generation, and statistical analysis
Venture management	34	169	John Leonard, VP	Venture teams that provide a core group of individuals with expertise in particular therapeutic areas. Responsible throughout development
Administration	20	113	Jeff Leiden, EVP	Support functions, such as finance, HR, engineering, and executive R&D management
Pharmaceutical Analytical Research & Development	59	337	Efraim Shek, DVP	Develops new products using analytical methods, manufactures for clinical trials, supports existing products
Regulatory Affairs/Quality Assurance	9	68	Mick Roebel, DVP	Overall regulatory support such as FDA licensing, regulatory submission, oversight of clinical work and toxicology
Phase I center, clinical pharmacology and pharmacokinetics	10	62	Rick Granneman, Director	Facility at VMH and other functions
Total	410	2,283		

* Rubison reports to Granneman

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ABBOTT VENTURES

Pharmaceutical Discovery	153.0
Drug Safety	39.0
Medical Affairs	19.0
Information Management & Technology	50.0
Development Operations	17.0
Venture Management	34.0
Administration	20.0
Pharmaceutical Analytical Research & Development	59.0
Regulatory Affairs/Quality Assurance	9.0
Phase I Center	10.0
Functional Subtotal	410.0
Clinical Grants	118.0
Services purchased*	47.0
SPD services purchased	53.0
Other	0.4
Total	629.0

	2001 plan (\$ Millions)	Headcount	VP OF TA
Anti-infective	8.7	42	E. Sun
Anti-viral	10.5	55	E. Sun
Analgesia	5.8	11	?
Urology	2.0	14	M. Verlinden
Oncology	7.4	47	P. Nisen
Total	34.0	169	

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2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5
Abbott International R&D	28.0
Hospital Products R&D	2.3
Recent additions to GPD subtotal	62.1
Abbott Discovery	192.0
Abbott Development	380.0
Abbott subtotal	572.0
TAP & Sister Division	57.0
Abbott total	629.0
x-Knoll Corp. Discovery	130.3
x-Knoll Corp. Development	258.3
x-Knoll other corporate	-30.5
x-Knoll local R&D	18.0
x-Knoll other*	34.0
x-Knoll total	410.0
R&D total	1,100.9

Integrin alpha-v-B3-inhibitors	6.1
PAI-1 mAb	4.0
Calpain inhibitor	11.1
T-cell PTK inhibitors	7.0
KDR-inhibitors	5.3
ICE-inhibitors	7.7
Oral thrombin inhibitors	11.8
ET receptor antagonists	6.7
Anti IL-18 mAb	11.8
PARP inhibitors	9.6
5HT1A receptor ligands	1.9
NIK inhibitors	6.0
Complement inhibitors	13.3
Bujard-Colaboration	(1.3)
Tie-2 inhibitors	4.5
Exploratory Research	4.5
Exploratory Research O/I	8.3
Other corporate research	12.0
Total	130.0

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

Note: x-Knoll data is preliminary

Source: R&D Finance

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KNOLL DISCOVERY SPEND BY LOCATION

Percent of project budget

Project	BASF	Knoll AG	KPC	KP UK	ABC	Italy	Spain	LKF	Canada	Japan	KJJK	Knoll BV	Belgium	Australia
Integrin alpha-v-B3-inhibitors		100												
PAI-1 monoclonal antibody		65			35									
Calpain inhibitor		100												
T-cell PTK Inhibitors					99									
KDR-Inhibitors					81		19							
ICE-Inhibitors		19			79									
Oral thrombin inhibitors	1	99												
ET receptor antagonists	1	99												
anti IL-18 mAB		10			90									
PARP inhibitors		100												
5HT1A receptor ligands		100												
NIK inhibitors					100									
Complement inhibitors	1	96			2									
Bujard-Colaboration		100												
Tie-2 Inhibitors		2			98									
Exploratory Research		100												
Exploratory Research O/I					100									
Other corporate research									1					

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2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5
Abbott International R&D	28.0
Hospital Products R&D	2.3

Recent additions to GPD subtotal**62.1**

Abbott Discovery	192.0
Abbott Development	380.0

Abbott subtotal**572.0**

TAP & Sister Division

57.0

Abbott total**629.0**

x-Knoll Corp. Discovery	130.3
x-Knoll Corp. Development	258.3
x-Knoll other corporate	-30.5
x-Knoll local R&D	18.0
x-Knoll other*	34.0

x-Knoll total**410.0****R&D total****1,100.9**

BSF 302146 (LU302146)	4.2
HSR-903	
T3/T4	9.3
Hokunalin tape	
Darusentan (LU 135252)	26.4
LU208075	4.5
PEG-Hirudin	21.4
Ancrod	1.0
BSF 201640	(2.3)
BSF 74398 (Parkinson)	
Dilaudid OROS	12.7
BSF 190555 (Schizophrenia)	
AU224	4.1
D2E7	98.2
SEGARD	11.7
J695	14.2
Clivarine	3.6
Meridia (Sibutramine)	21.8
Trandolapril (patch, intervention trials)	
LU420627 (BSF 420627)	4.8
Propafenone-HCL (Rythmol SR)	9.2
Corp. Development non TA	13.5
Total	258.3

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

Note: x-Knoll data is preliminary

Source: R&D Finance

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KNOLL 2001 PLAN DEVELOPMENT SPEND INTERNAL/EXTERNAL

\$ Millions

	Total	Internal	External	Depreciation
• BSF 302146 (LU302146)	4.2	3.9	0.3	
• HSR-903				
• T3/T4	9.3	4.5	4.8	
• Hokunalin tape				
• Darusentan (LU 135252)	26.4	12.9	13.5	
• LU208075	4.5	3.2	1.3	
• PEG-Hirudin	21.4	8.1	13.3	
• Ancrod	1.0	0.3	0.7	
• BSF 201640	(2.3)	(2.1)	(0.2)	
• BSF 74398 (Parkinson)				
• Dilaudid OROS	12.7	5.9	5.9	0.9
• BSF 190555 (Schizophrenia)				
• AU224	4.1	2.3	1.8	
• D2E7	98.2	48.1	49.7	0.4
• SEGARD	11.7	5.9	5.8	
• J695	14.2	7.7	6.3	0.2
• Clivarine	3.6	1.8	1.8	
• Meridia (Sibutramine)	21.8	11.0	10.8	
• Trandolapril (patch, intervention trials)				
• LU420627 (BSF 420627)	4.8	4.1	0.7	
• Propafenone-HCL (Rythmol SR)	9.2	5.6	3.6	
• Corp. development non-TA	13.5	11.5	2.0	
Total	258.3	134.8	122.0	1.5

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KNOLL DEVELOPMENT SPEND BY LOCATION

Percent of project budget

Project	BASF	Knoll AG	KPC	KP UK	ABC	Italy	Spain	LKF	Canada	Japan	KJJK	Knoll BV	Belgium	Australia
BSF 302146 (LU302146)		98												
HSR-903														
BSF 420627 (ETA/BPH)														
T3/T4			100											
Hokunalin tape														
Darusentan (LU 135252)		66	33											
LU208075 (endothelin antagonist)	2	93				1								
PEG-Hirudin		40	57	1		2			2					
Ancrod (Viprinex)		100												
BSF 201640		96	4											
BSF 74398 (Parkinson)														
Dilaudid OROS		18	42	40										
BSF 190555 (Schizophrenia)														
Ganaton (pro-kinetic)														
TU-199 (proton pump inhibitor)														
AU-224 (colon pro-kinetic)														
D2E7	20	20	49	3	19	1	1	1	2	2	1	1	1	1
SEGARD	48	48	50		2									
J695	6	6	63		31									
Cilvarine	64	64							3					
Meridia (Sibutramine)	16	16	33	34						9	33			
Trandolapril (patch, intervention trials)											9			
LU420627	4	94				2								
Propafenone-HCL		26	72	1		1								
Corp. Development non TA	27					10	2	2		59				

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EMPLOYEES BY FUNCTIONAL AREA – LUDWIGSHAFEN**MARCH 5, 2001**

Function	Headcount	FTEs	Temp	Exempt headcount	Non-exempt headcount
Discovery Research Head Office	4	3.8	0	1	3
Biochemistry & Cell Biology	34	30.8	0	0	28
Medicinal Chemistry	56	53.6	2	13	42
High Throughput Screening	18	16.8	1	4	14
Compound analysis for HTS	7	6.2	0	1	6
Compound library & dispensation	9	7.8	1	0	9
Research Services (dfti wash & ship)	23	22.2	1	1	21
Medical Technology	25	23.4	0	8	19
Pharmacology	72	68.6	0	14	61
TET systems	2	2.0	2	1	0
Discovery Research	255	235.0	6	51	204
Pharmaceutical Centers Head Offices	9	8.6	0	3	6
Chemical Process Development	25	24.8	1	5	20
Chemical Analytical Development	8	7.2	0	2	6
Radiochemistry	5	5.0	0	3	2
Janitors	2	2.0	0	0	2
Radiochemistry (legally required)	1	1.0	0	1	0
Animal Development	23	21.2	1	5	21
Animal Support	11	10.0	2	6	6
Formulation Development Oral	15	13.8	2	4	11
Formulation Development Parenteral	16	15.0	2	6	10
Bioanalysis	27	23.8	2	8	17
Drug Disposition - Kinetics	23	21.0	1	4	9
Early ADME	13	12.6	0	2	2
Pharmacokinetics & Pathology	4	4.0	0	2	2
Physiology & Pharmacology	25	23.2	1	9	20
Clinical Chemistry & Employee Chem.	7	6.2	1	6	6
Bioresource Facility (ARF)	22	22.0	0	0	22
Pharmaceutical Centers	239	227.0	11	58	180
Clinical Dev. CV	29	27.0	1	10	18
Clinical Dev. Immunology	21	20.2	2	8	13
Clinical Operations	1	1.0	0	1	0
Clinical Pharmacology	15	14.8	6	8	11
BDM Head Office & ClinPharm Biostat.	7	6.2	2	3	4
Clinical Biostatistics	9	8.6	2	4	4
Clinical Detachment	25	22.2	1	7	18
Clinical Centers	111	103.0	12	41	70
Global Projects Head Office & GTLs	4	4.0	0	3	1
Project Management	5	5.0	0	3	2
Project Coordination	5	4.6	0	1	4
Global Projects	14	13.6	0	7	7
Reg Affairs Head Office & Labeling	4	4.0	0	3	1
Electronic Document Management	2	1.8	0	1	1
Quality Assurance GTP	8	8.0	0	4	4
Dossier Production & Reg. Compliance	5	5.0	0	3	2
Language Services (Translation)	5	4.2	0	1	4
Scientific Document Service	2	2.0	0	1	1
Emergency Reg Affairs	3	3.0	0	3	0
Country Support	6	6.0	0	2	7
Pharmacoepidemiology	10	9.2	0	2	7
Regulatory Centers	48	46.0	0	22	26
SPTS Head Office/Head Serv./CRO Mgmt.	6	6.0	0	1	5
Lab supplies	3	3.0	0	0	3
Information Services Head Office	3	2.2	0	1	2
Literature Services Head Office	5	4.8	2	1	4
Library & Literature Services	8	6.4	0	2	6
Phys. Mgmt. & High Security Archive	4	4.0	0	1	3
Development IT	15	14.4	1	1	11
Bioinformatics, non-clinical	4	4.0	0	2	2
Research IT	4	4.0	0	0	4
R&D Controlling -non RAD HC>	<5>	<4.2>	<0>	<2>	<3>
Systems, Processes & Support	52	47.6	6	12	48
Total R&D Knell AG	719	672.0	34	182	827

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Appendix

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BUDGET BY THERAPEUTIC AREA

Therapeutic area	Project	Origin	Priority	Phase	Reviewed	2001 plan	(S) small molecule (B) biological	Comment
Anti-Infective	• Clarithromycin (Blaxin)	Abbott	C	IV	Y	14.9	S	Antibiotic
	• ABT 492 (Quinolone)	Abbott	C	I	Y	24.5	S	Respiratory antibiotic
	• ABT 773 (Ketolide)	Abbott	C	III	Y	88.0	S	Antibiotic; bronchitis
	• HSR 903	Knoll	T	III	Y	0.0	S	Quinolone
	• Omnicef	Abbott	C	IV	Y	4.9	S	antibiotic Cephalosporin
Anti-viral	• Triangle projects (HIV and HBV)	Abbott JV	?	?	N	?	S	
	• Kaletra	Abbott	C	IV	Y	51.0	S	Protease inhibitor
	• Norvir (ritonavir)	Abbott	C	IV	Y	4.0	S	Protease inhibitor
Asthma	• Hokunalintape (tulobuterol)	Knoll	P	Pre-clinical	Y	0.0	S	(Beta-2) agonist/asthma
Cardiology	• ABT 187 (r-proUK; recombinant protein)	Abbott	C	III	Y	0.0	B	Acute stroke
	• Urokinase	Abbott	C	III	Y	0.0	B	?
	• Ancrod (viprinex)	Knoll	T	III	Y	1.0*	B	Acute ischemic stroke
	• Cilvarine	Knoll	C	IV	Y	3.6	B	LMW heparin; thrombosis
	• Darusentan (LU 135252)	Knoll	H	III/III	Y	26.6	S	Endothelin A antagonist
	• Levosimendan (sindax)	Abbott	C	IV	Y	0.0	?	Calcium sensitizer
	• LU208075 (BSF 208075)	Knoll	H	I	Y	4.2	S	Congestive heart failure
	• PEG-Hirudin (pegmusirudin)	Knoll	P	II	Y	16.0	B	Thrombin inhibitor
	• Rhythmol SR (propafenone)	Knoll	C	III/IV	Y	9.2	S	Anti-arrhythmic
	• Trandolapril (patch, intervention trials)	Knoll	P	I		0.0	S	Transdermal ACE inhibitor

Source: R&D finance; Development Review templates; team analysis

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BUDGET BY THERAPEUTIC AREA (CONTINUED)

Therapeutic area	Project	Origin	Priority	Phase	Reviewed	2001 plan	(S) small molecule (B) biological	Comments
Endocrine	• T3/T4	Knoll	P	Pre-clinical IV	Y	9.3	B	Hypothyroidism
	• Meridia (Sibutramine)		H		Y	21.8	?	?
Gastroenterology	• AU 224 (colon pro-kinetic)	Knoll	C	I	Y	4.1	S	Chronic constipation
	• Ganaton (pro-kinetic)	Knoll	P	II	Y	0.0	S	Gastric Dismotility,
	• TU-199	Knoll	T	IV (Japan)	Y	0.0**	S	Proton pump inhibitor
Immunology	• D2E7 (adalimumab)	Knoll	C	III	Y	98.2	B	Arthritis; anti-TNF alpha mAb
	• J695	Knoll	P	II	Y	14.2	B	Anti-IL12 mAb; arthritis
	• SEGARD	Knoll	H	III	Y	11.7	B	Sepsis
Metabolic	• Fenofibrate (Fournier stricon)	Abbott	C	IV	Y	1.4	S	Hypertriglycerodemi a
	• Uprima	TAP/ Abbott	C	IV	Y	0.0***	S	Erectile dysfunction
Neuroscience	• Gabatril	Abbott	?	IV	N	1.4	?	GABA uptake inhibitor
	• ABT 598 (KCO)	Abbott	?	I	N	5.0	?	Overactive bladder
	• ABT 594 (CCM)	Abbott	P	II	Y	9.3	S	Diabetic pain
	• ABT 963 (Cox-II)	Abbott	C	I	Y	1.2	S	Osteoarthritis
	• Bimoclomol (ABT 822)	Abbott	P	II	Y	0.0	?	Diabetic neuropathy
	• ABT 089	Abbott		I	N	0.6	S	Alzheimers
	• BSF 201640	Knoll	P	I/II	Y	(2.3)	S	Schizophrenia
	• BSF 74398 *	Knoll	C	II	Y	0.0	S	Parkinson's
	• BSF 190555	Knoll	P	I/II	Y	0.0	S	Schizophrenia
	• Dilaudid Oros (Hydromorphone SR)	Knoll	H	IV	Y	12.7	S	To treat pain
	• Depakote	Abbott	C	IV	Y	24.1	S	Epilepsys migraine
	• Hydrocodone (RP Scherer Alza)	Abbott	C	I	Y	4.0	S	Acute pain

* Cancelled

** May be funded by locally

*** May be funded by AI

Source: R&D finance; Development Review templates; team analysis

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BUDGET BY THERAPEUTIC AREA (CONTINUED)

Therapeutic area	Project	Origin	Priority	Phase	Reviewed	2001 plan	(S) small molecule (B) biological	Comments
Oncology	• ABT 510 (Tsp. no. 1)	Abbott	C	I	Y	10.0	S	Solid tumors
	• ABT 751 (anti-tubulin)	Abbott	C	I	Y	8.4	S	Solid tumors
	• ABT 627 (endothelin)	Abbott	C	III	Y	38.8	S	Prostate cancer
	• ABT 518 (metallo-protease)	Abbott	H	I	Y	7.4	S	Solid tumors
	• Rubitecan	Abbott (HPD)	P	III	Y	0*	S	Topoisomerase I inhibitor
	• Theragyn	Abbott (HPD)	P	III	Y	0*	B	Ovarian cancer (mAb)
Urology	• BSF 420627 (ETA/BPH)	Knoll	P	I	Y	4.8	S	Benign prostate hyperplasia
	• ABT 980 (BPH backup)	Abbott		Killed		2.3	S	Benign prostatic hyperplasia
Other	• Gengraf (Cyclosporine)	Abbott	C	IV	Y	0	S	Immuno-suppressant
	• BSF 302146	Knoll	?	?	N	4.2	?	?
	• Norvir		C		Y			
	• ABS 103/NRS 1776	Abbott			N			
	• ABT-677 (Nevraminidase)	Abbott			N			
	• ABT-828 (45)	Abbott			N			
	• FTI	?						
	• Ritonovir	?						
	• TSP-2	?						

* May be funded by HPD

Source: R&D finance; Development Review templates; team analysis

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CH-228011-079jb/rcDC

POTENTIAL SAVINGS FROM TERMINATING DEVELOPMENT PROJECTS

\$ Millions

PRELIMINARY

Program name	Priority	2001 potential savings (external only)	2001 planned budget \$ Millions		2001 budget if killed mid-May \$ Millions		Total
			External	Internal	External	Internal	
ABT-518 (MMP1)	Terminate	0.90	1.10	8.30	0.20	4.40	4.60
Darifenian	Terminate	10.57	13.50	12.90	2.93	6.84	9.77
Dilaudid	Terminate	2.95	5.90	5.90	?	?	?
SEGAD	Terminate	2.90	5.80	5.90	?	?	?
T3/T4	Pending	2.40	4.80	4.50	?	?	?
ABT-594	Pending	0.24	1.30	8.00	1.06	7.65	8.71
J695	Pending	(0.30)	6.30	7.70	6.80	3.60	10.20
PEG Hlirudin	Pending	6.65	13.30	8.10	?	?	?
ABT-492 (Quinolone)	Continue	6.00	7.10	17.40	1.10	8.00	9.10
ABT-510 (TSP-1)	Continue	2.10	2.30	7.70	0.20	5.90	6.10
ABT-627 (Endothelin)	Continue	17.80	19.90	18.90	2.10	12.80	14.70
ABT-751 (Anti-Mitotic)	Continue	1.60	1.60	6.60	-	3.50	3.50
ABT-773 (Ketolide)	Continue	21.70	54.80	33.20	33.10	27.30	60.40
ABT-963 (COX-II)	Continue	(0.03)	0.10	1.10	0.13	1.10	1.23
AU224	Continue	0.30	1.80	2.30	1.50	0.40	1.90
Clarithromycin	Continue	4.70	12.00	2.90	7.30	3.30	10.60
Cilvarine	Continue	0.90	1.80	1.80	?	?	?
D2E7	Continue	24.85	49.70	48.10	?	?	?
Depakote	Continue	4.50	10.00	14.40	5.50	10.80	16.10
Fenofibrate	Continue	-	-	1.40	-	1.40	1.40
Hydrocodone	Continue	-	-	4.00	?	?	?
Kaletra	Continue	8.00	24.30	26.70	16.30	17.10	33.40
Omticef	Continue	2.90	3.00	1.90	0.10	1.50	1.60
Propafenone SR	Continue	1.80	3.60	5.60	?	?	?
Sibutramine	Continue (?)	3.50	10.80	11.00	7.30	4.20	11.50
Gengraf	Continue	(0.20)	1.20	1.30	1.40	0.70	2.10
ABS103/NPS1776	Not reviewed	-	-	-	-	0.20	0.20
ABT-089 (ADHD)	Not reviewed	-	-	0.60	-	0.60	0.60
ABT-598 (KCO)	Not reviewed	0.40	0.40	4.60	-	1.40	1.40
Ritonovir	Not reviewed	0.80	1.90	2.10	1.10	2.10	3.20

Note: Assumes savings of 50% of external costs if project team did not answer survey; shows only projects funded in 2001 PPD and Knoll plans: unfunded projects listed as terminate/hold include Trandolapril, HSR903, and Ancrod; unfunded projects listed as pending include Rubitecan, Theragyn, Urokinase, BSF201640, BSF 190555, ABT-822, LU420627, Ganaton, and Hokinulin Tape; unfunded projects listed as continue include BSF 190555, Levosimendan, Pro-urokinase, Norvir, and Uprima.

Source: R&D Finance survey of project teams

CH-228011-079jb/rcDC

MODEL "MAY 8" PORTFOLIO

	Theoretical portfolio including biologicals	Potential total*	Projects in potential total that were not funded in 2001 plans	Projects in potential total currently funded	Current Biologicals (all funded)	Theoretical portfolio without biologicals
Pre-Phase I	8	1**	0	1**	1	7**
Phase I	6	12	2	10	0	6
Phase II	12	9	3	6	2	10
Phase III	5	11	3	8	6	3***
Phase IV – clinical	5	12	3	9	0	5
Phase IV – other	12	–	–	–	–	12
Total	48	44	11	34	9	43
Total (I-IV)	40	43	11	33	8	36
Total (I-IV-clinical)	28	43	11	33	8	24

* All projects considered in development review

** Most pre-Phase I not funded in development budget

*** Not additive

CH-228011-079jbr/dc

DRAFT**"IDEAL" PIPELINE**

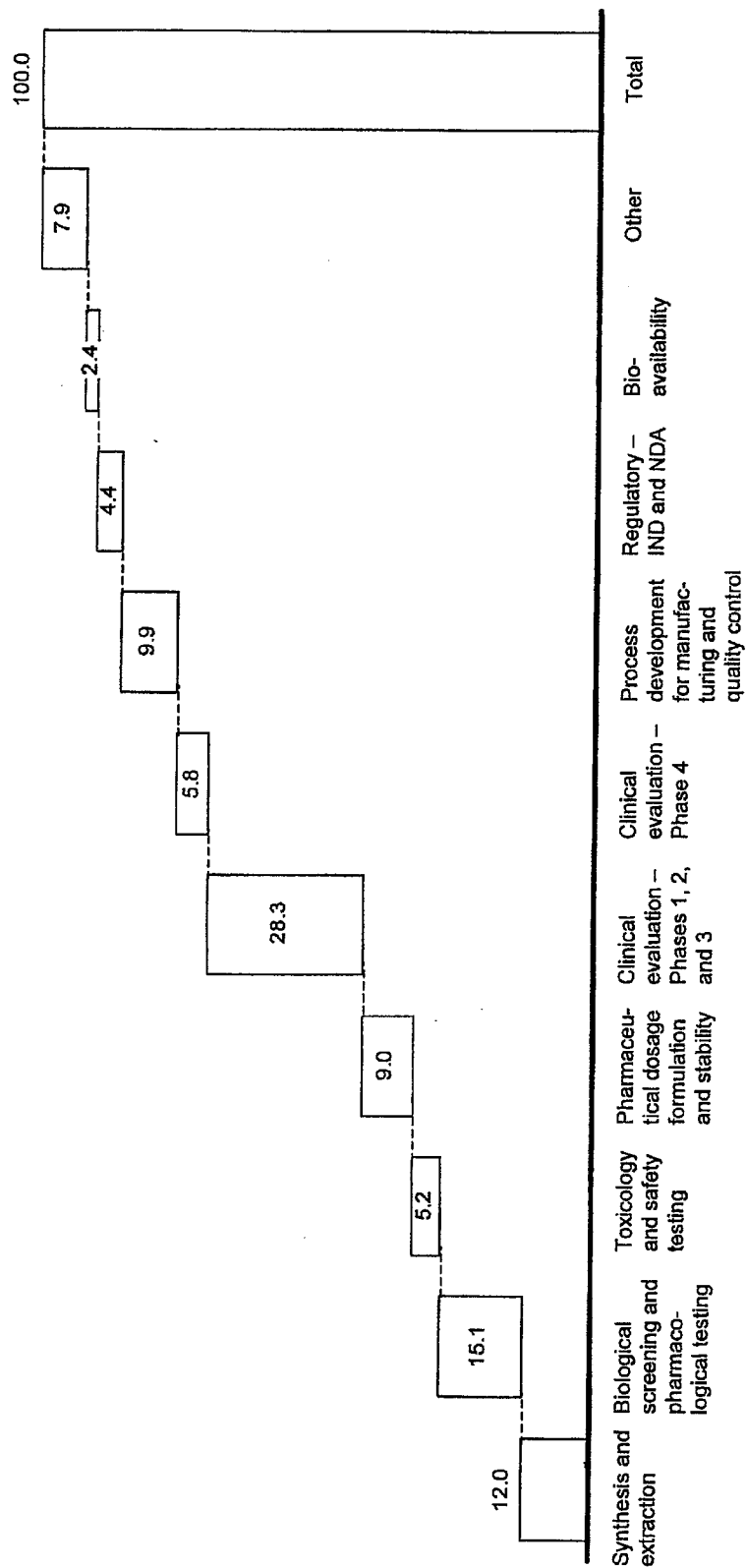
	Dollars Percent	Success rate Percent	NCE Percent	Number of projects steady-state
Pre-phase I	9	17	37	5.9
Phase I	14	25	17	2.8
Phase II	40	33	26	4.2
Phase III	37	65	19	3.2
Total				16.1

Note: Excludes phase IV. Assumes 1 NDA every 17 months. Phase I is after DDC, before first in man
Source: Abbott portfolio model

CH-228011-079b/rcDC

ALLOCATION OF DOMESTIC R&D EXPENDITURES BY FUNCTION – 1998

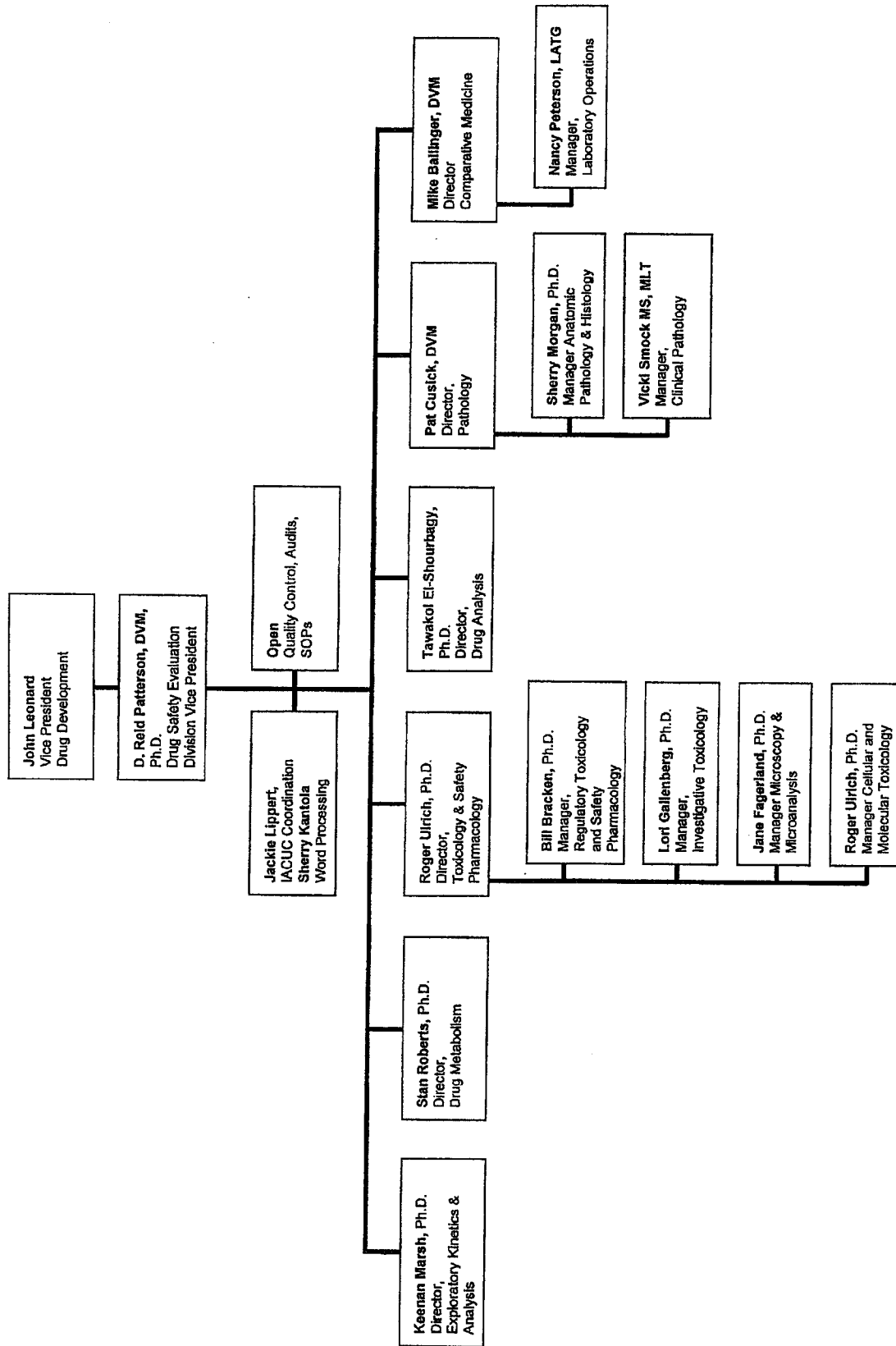
Percent



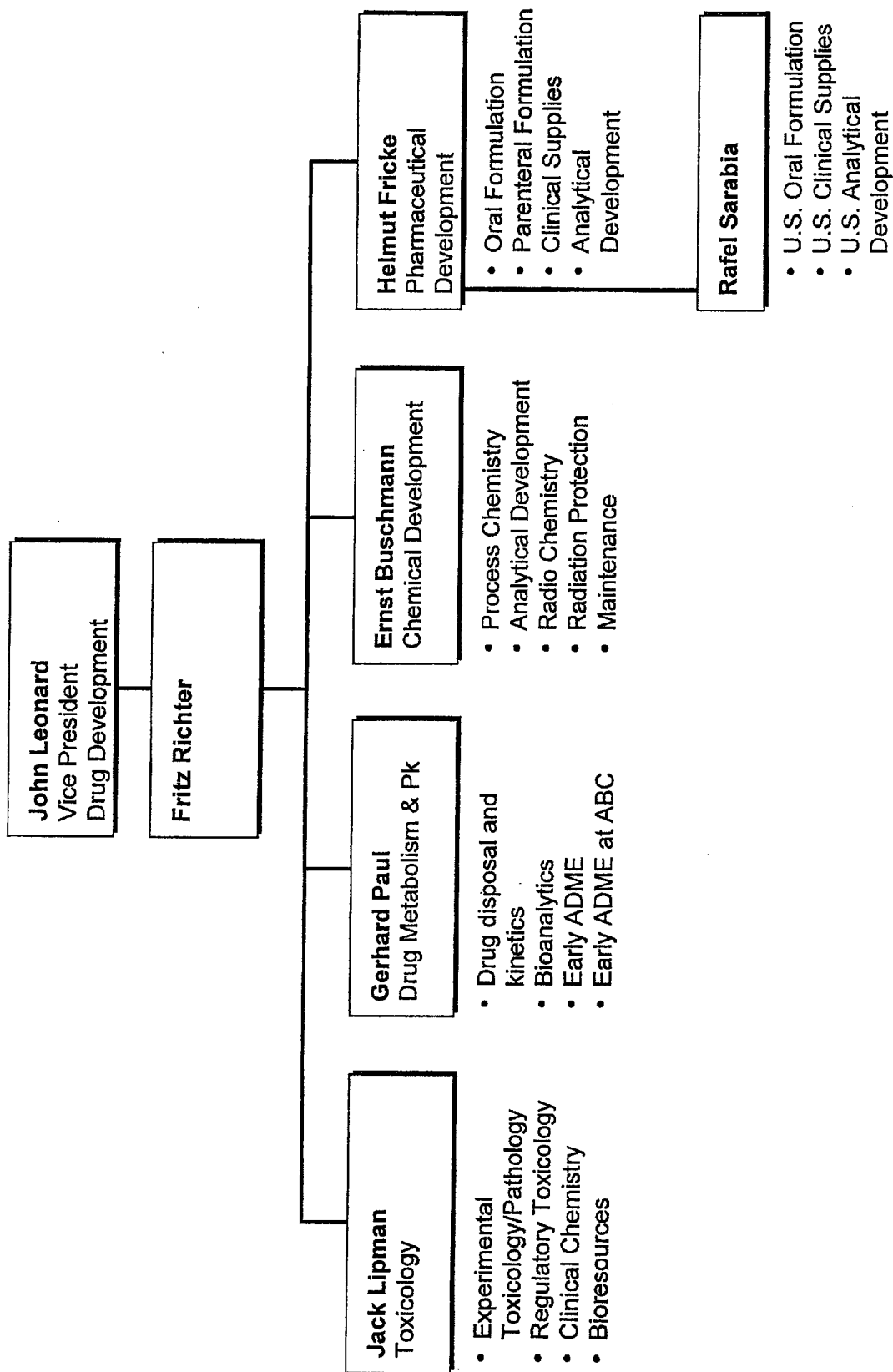
Source: PhRMA, 2000

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CH-228011-079jbrdDC

ABBOTT TOXICOLOGY

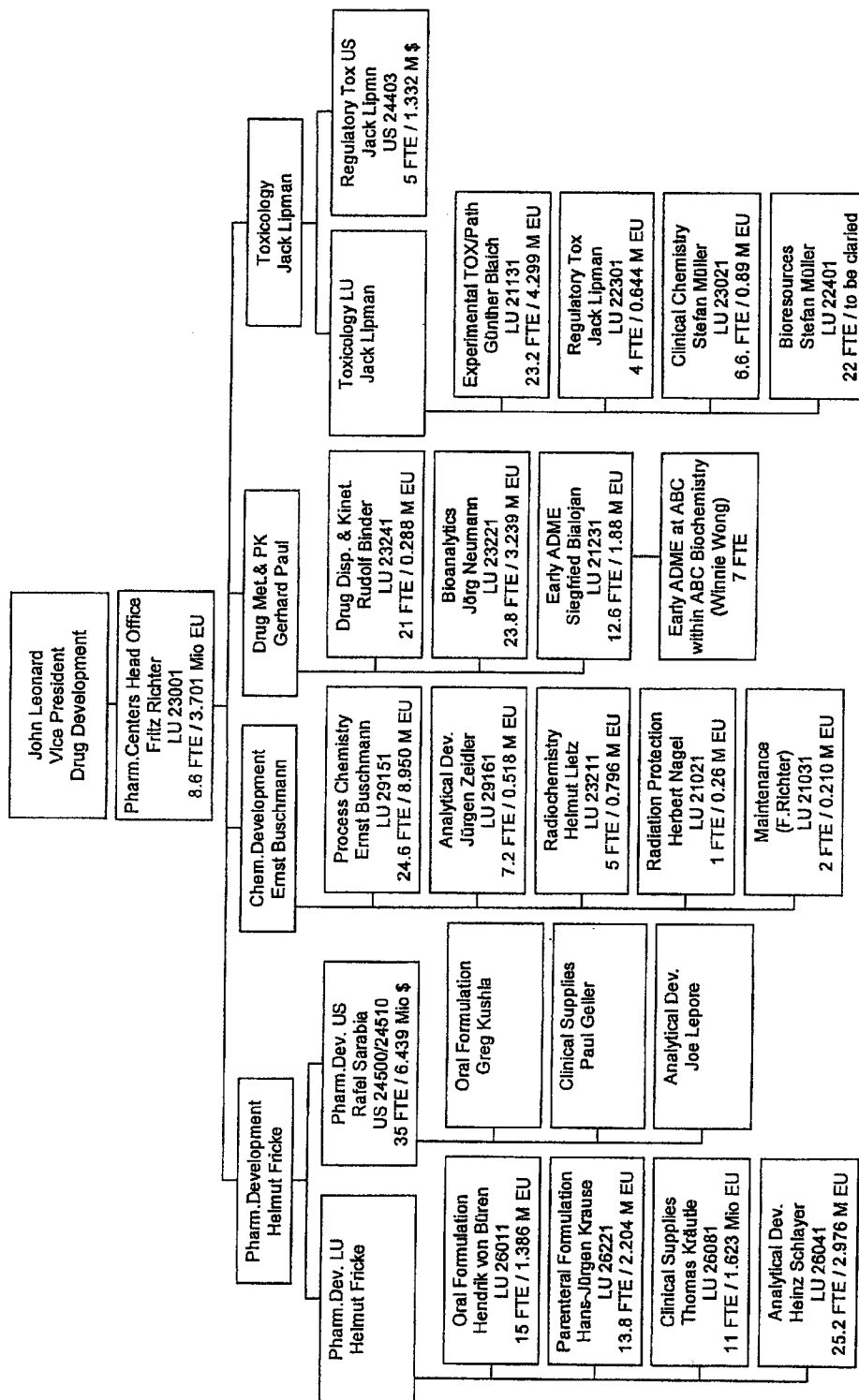
CH-228011-079jlr/dc

MARCH 2001**X-KNOLL PHARMACEUTICAL CENTERS**

CH-228011-079jb/rcDC

MARCH 2001**X-KNOLL PHARMACEUTICAL CENTERS**

FTE, millions Euro



1 # FTE is effective headcount on board March 5, 2001

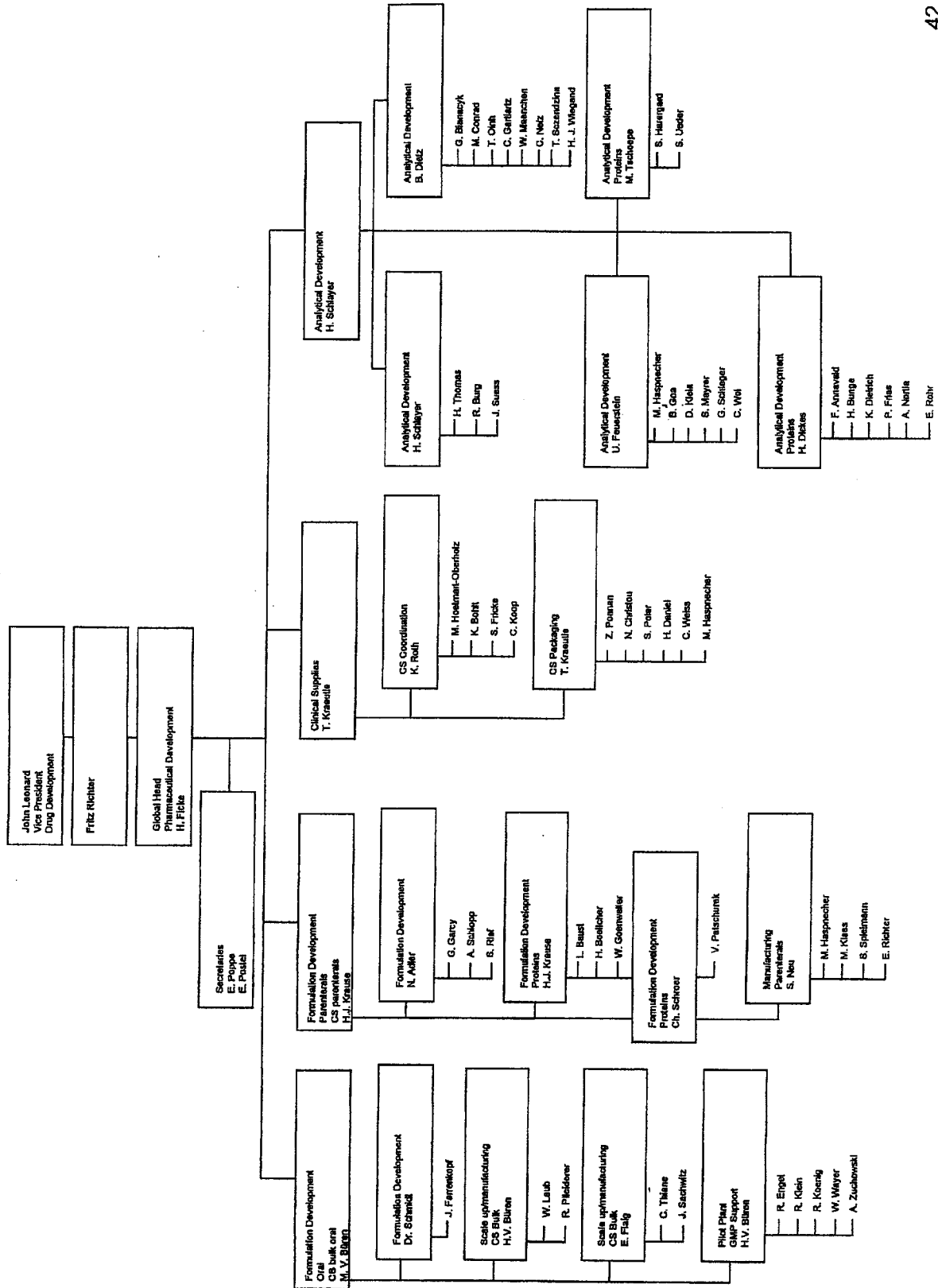
2 Budget figures don't include allocations by central functions e.g. HR, Site infrastructure, other central services

3 Cost distribution between 26011 and 26081 not accurate since recently some FTE + Equipment were moved from one to the other group which is not yet reflected in the budget

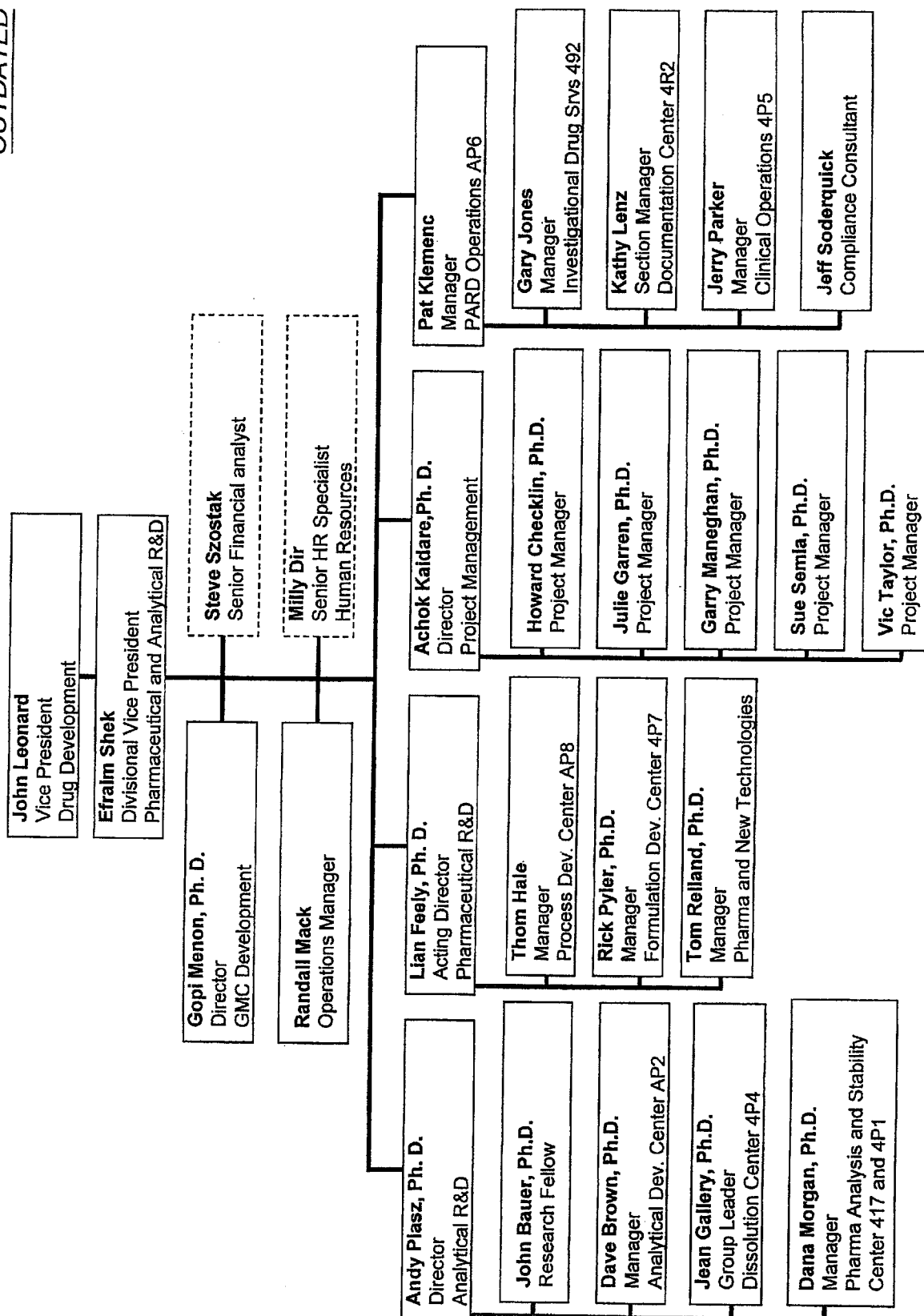
4 Budget of head office contains all administrative/management personnel incl. Department heads and several central costs e.g. temporary personnel, space, consultancy, depreciation on tangible assets

CH-228011-079jbrdc

X-KNOLL PHARMACEUTICS DEVELOPMENT

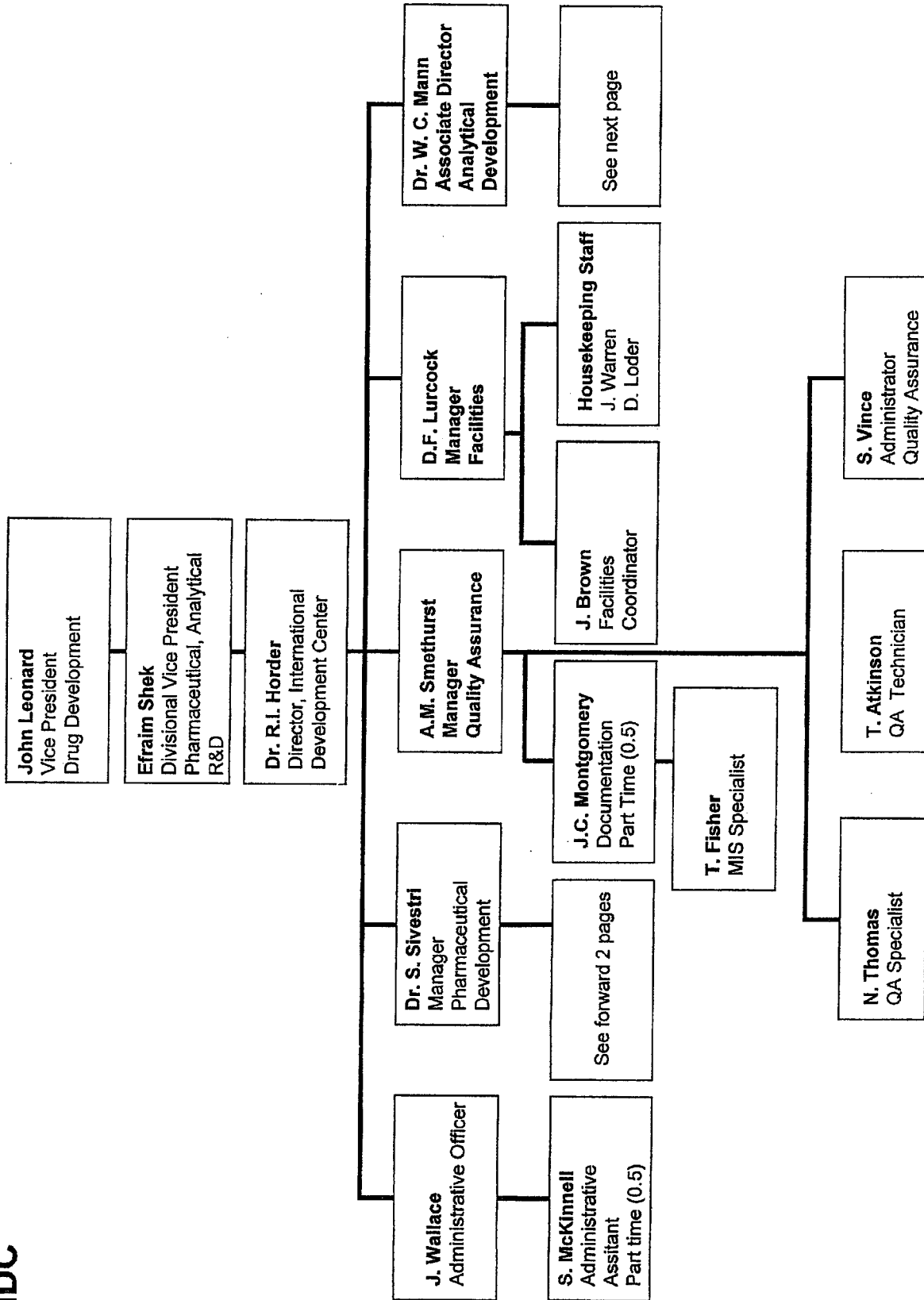


CH-228011-079jb/rcDG

OUTDATED**NORTH CHICAGO PARD**

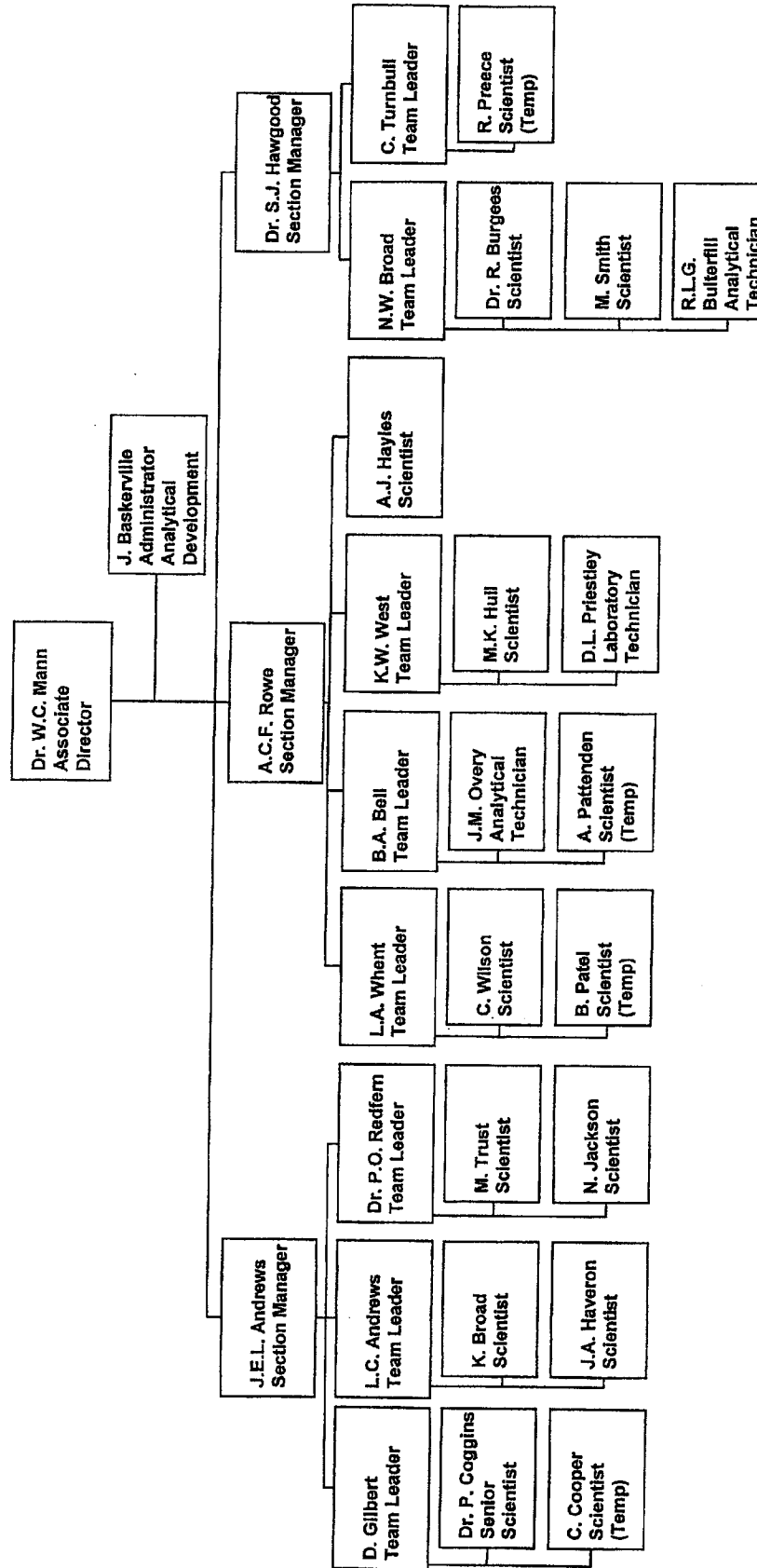
CH-228011-079jb/rcDC

IDC



CH-228011-079jbr/cdC

IDC ANALYTICAL DEVELOPMENT

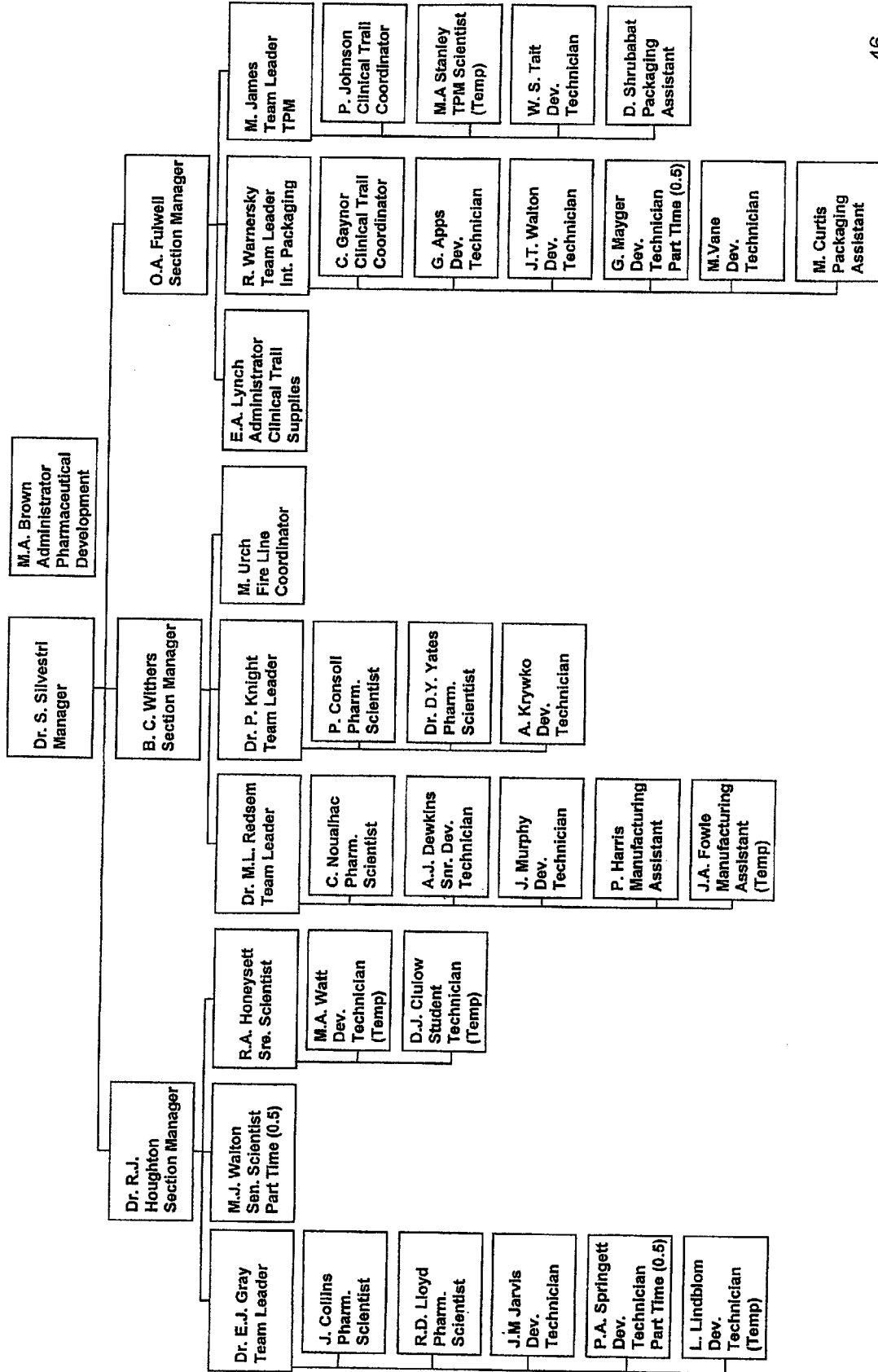


Note: n = 30

45

CH-228011-079jb/rcDC

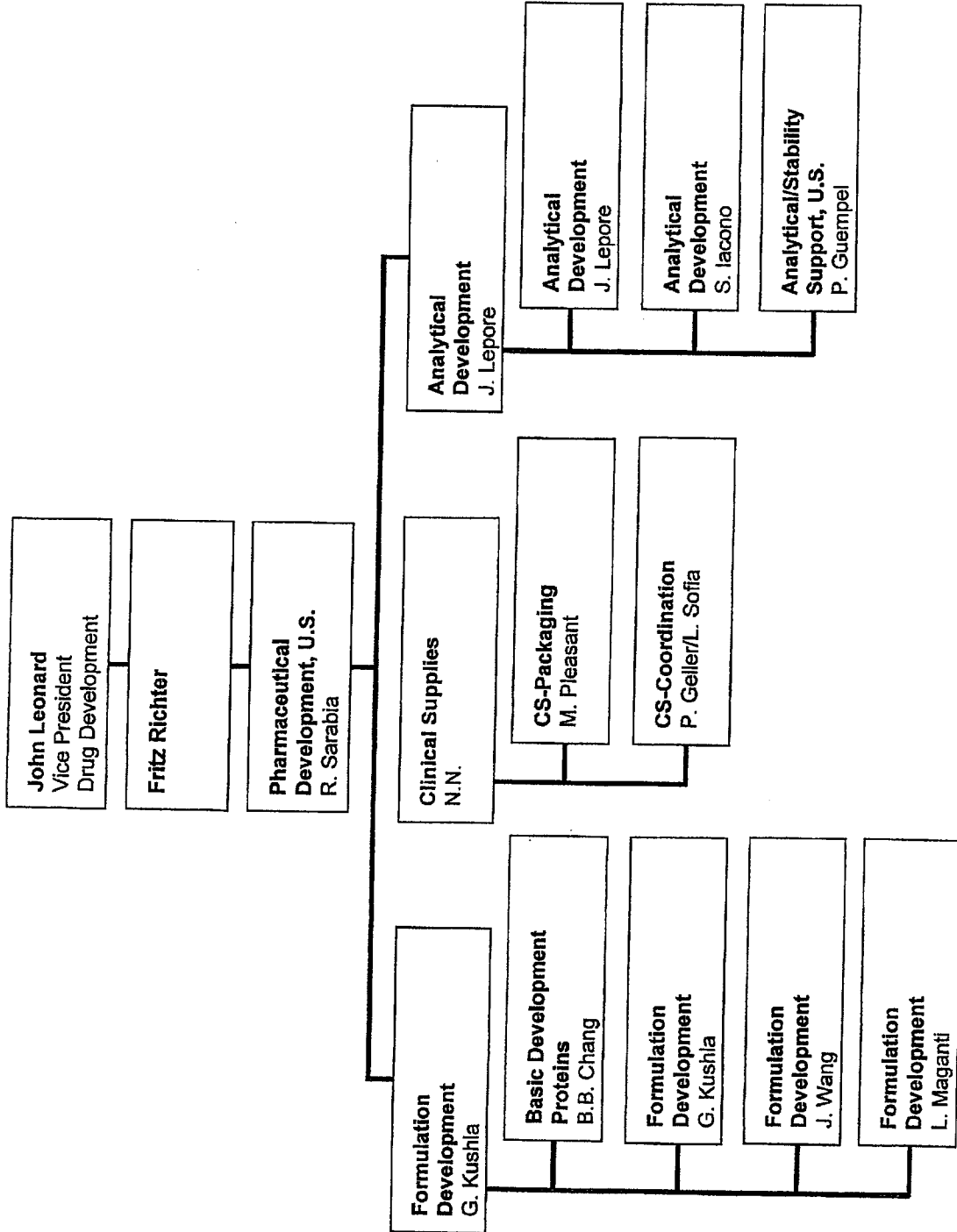
IDC PHARMACEUTICAL DEVELOPMENT



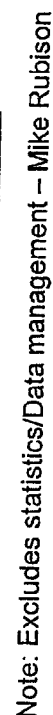
CH-22801 1-079jbr/roDC

JAN 2001

NEW JERSEY PHARMACEUTICAL DEVELOPMENT



CONFIDENTIAL



Center of Clinical Pharmacology and Pharmacokinetics

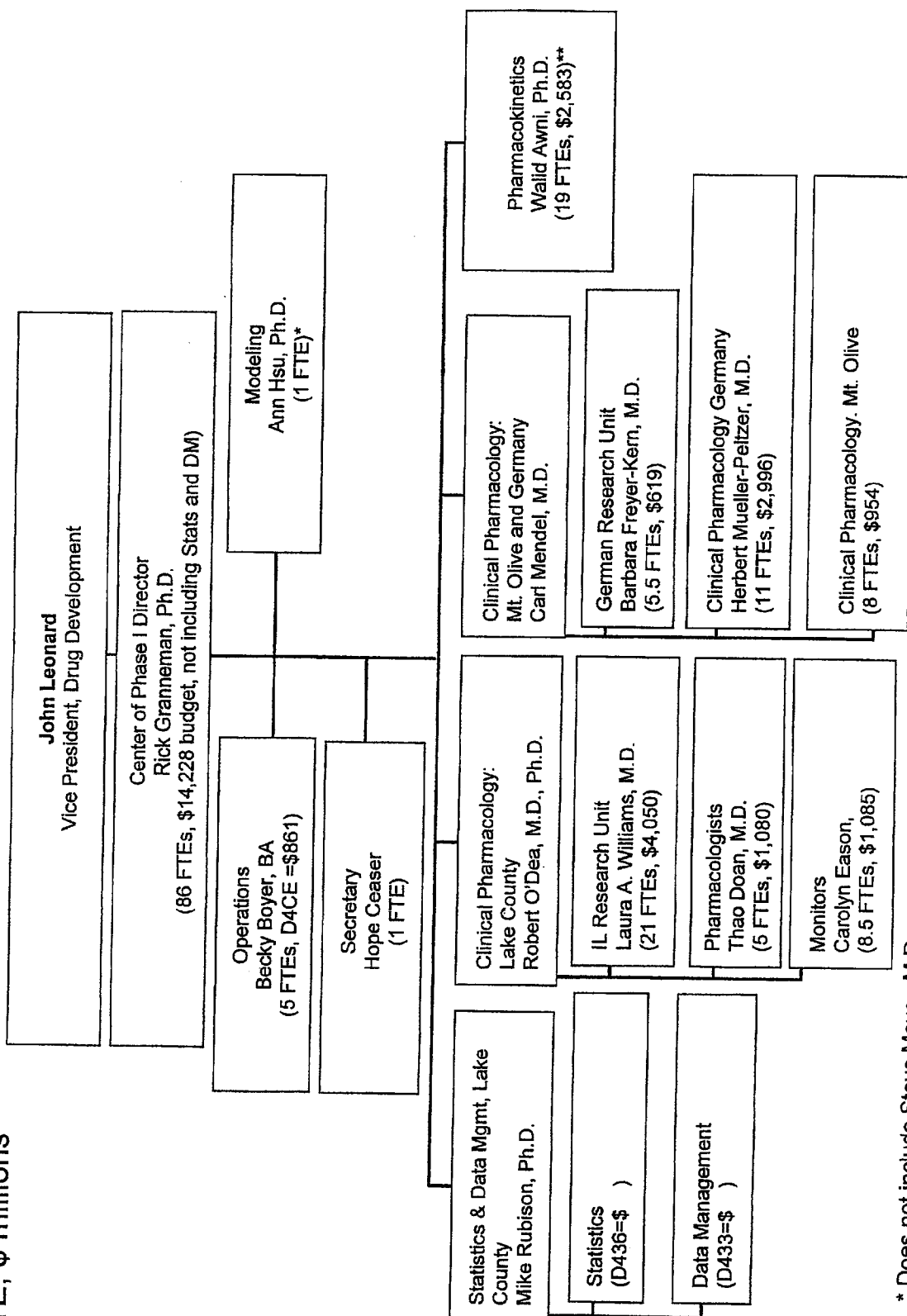
- D4CE – Center Management
- D42P – Clinical Pharmacology
- D420 – Clinical Pharmacology: Phase I Specialists
- D42K – ACPRU
- D4PK – Clinical Pharmacokinetics

CH-228011-079jb/rcDC

MARCH 2001

ABBOTT PHASE I ORGANIZATION

FTE, \$ millions

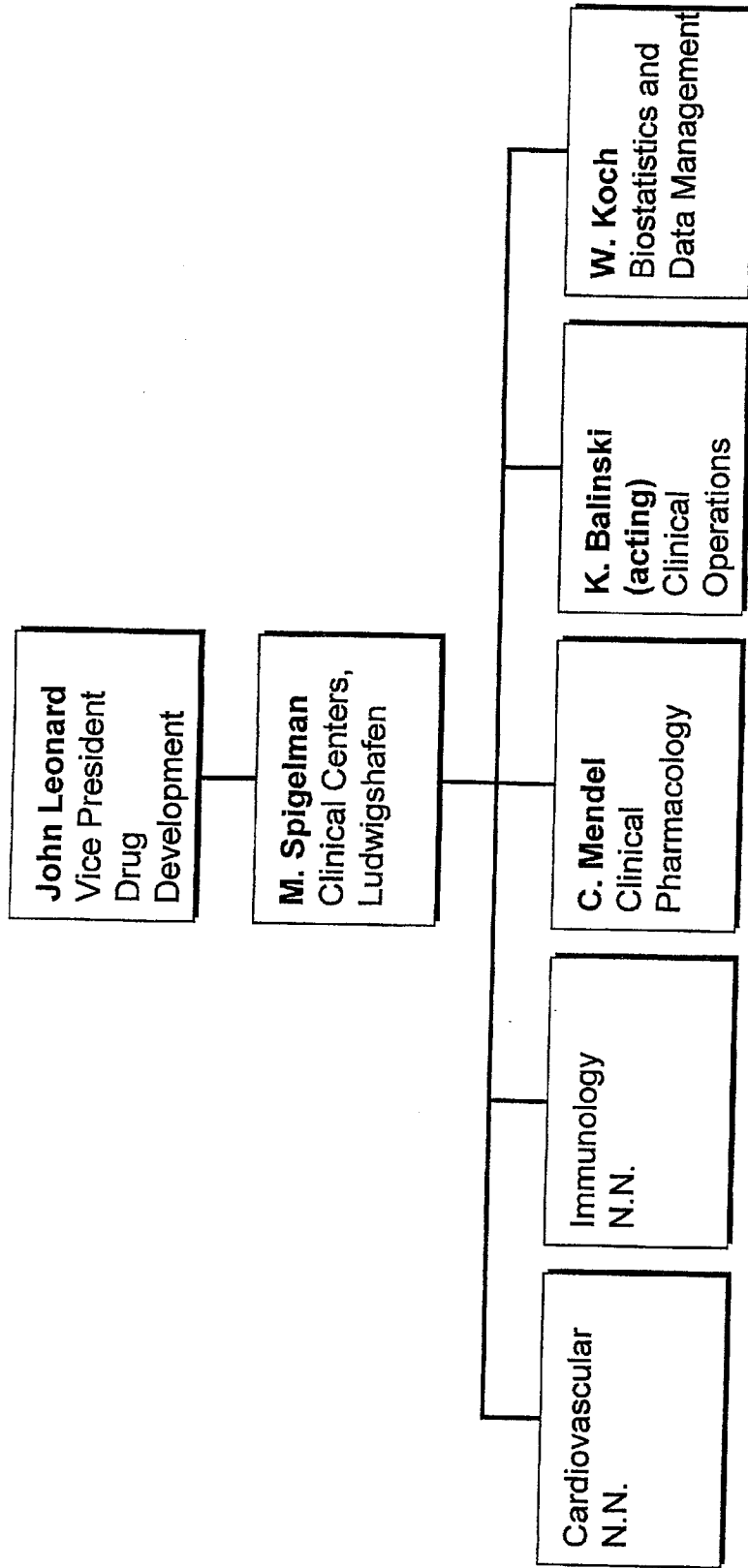


* Does not include Steve Mayer, M.D.

** Does not reflect new Ph.D. headcount from April Update

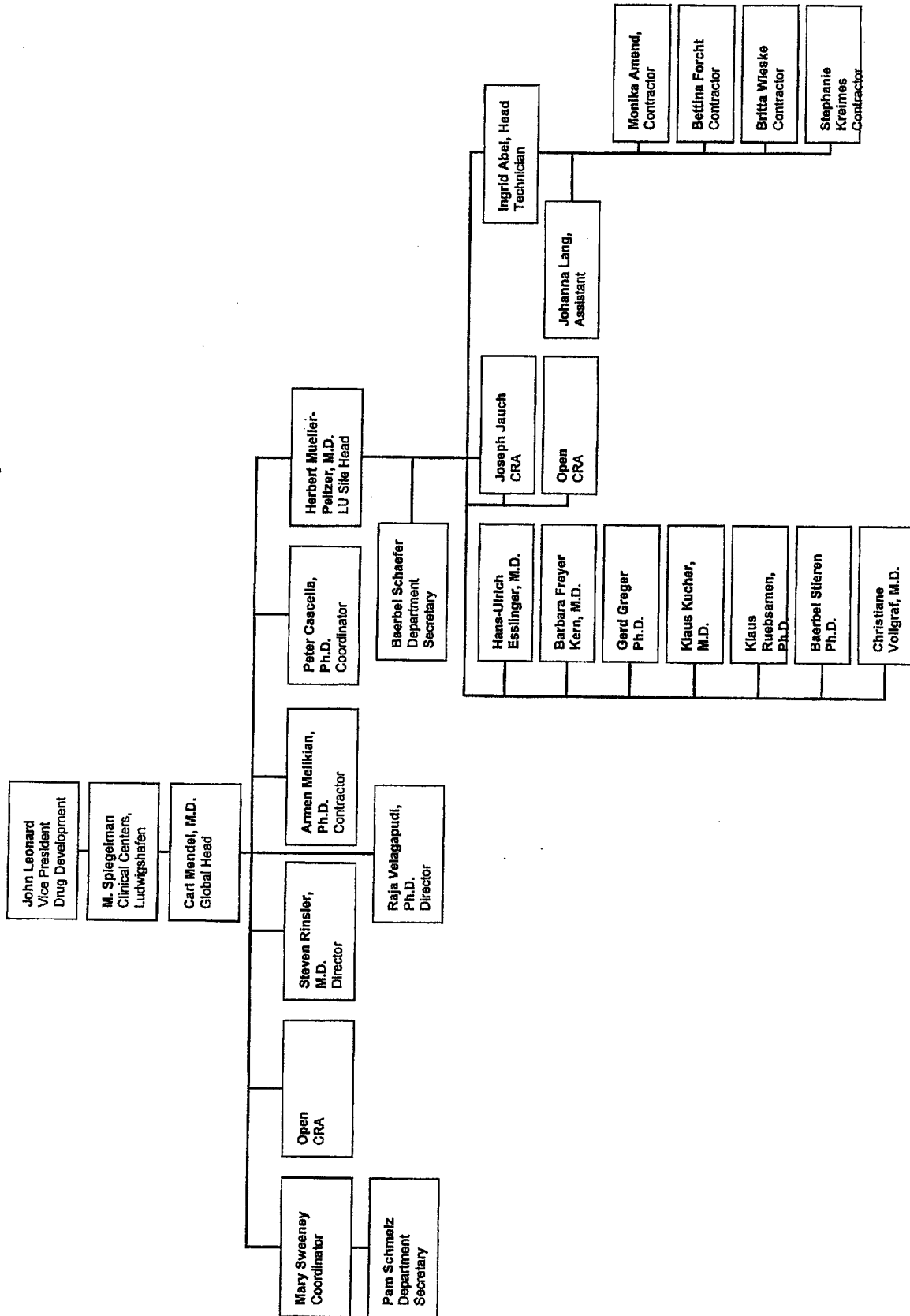
CH-228011-079jbr/cDC

X-KNOLL CLINICAL CENTERS



CH-228011-079jbr/cdc

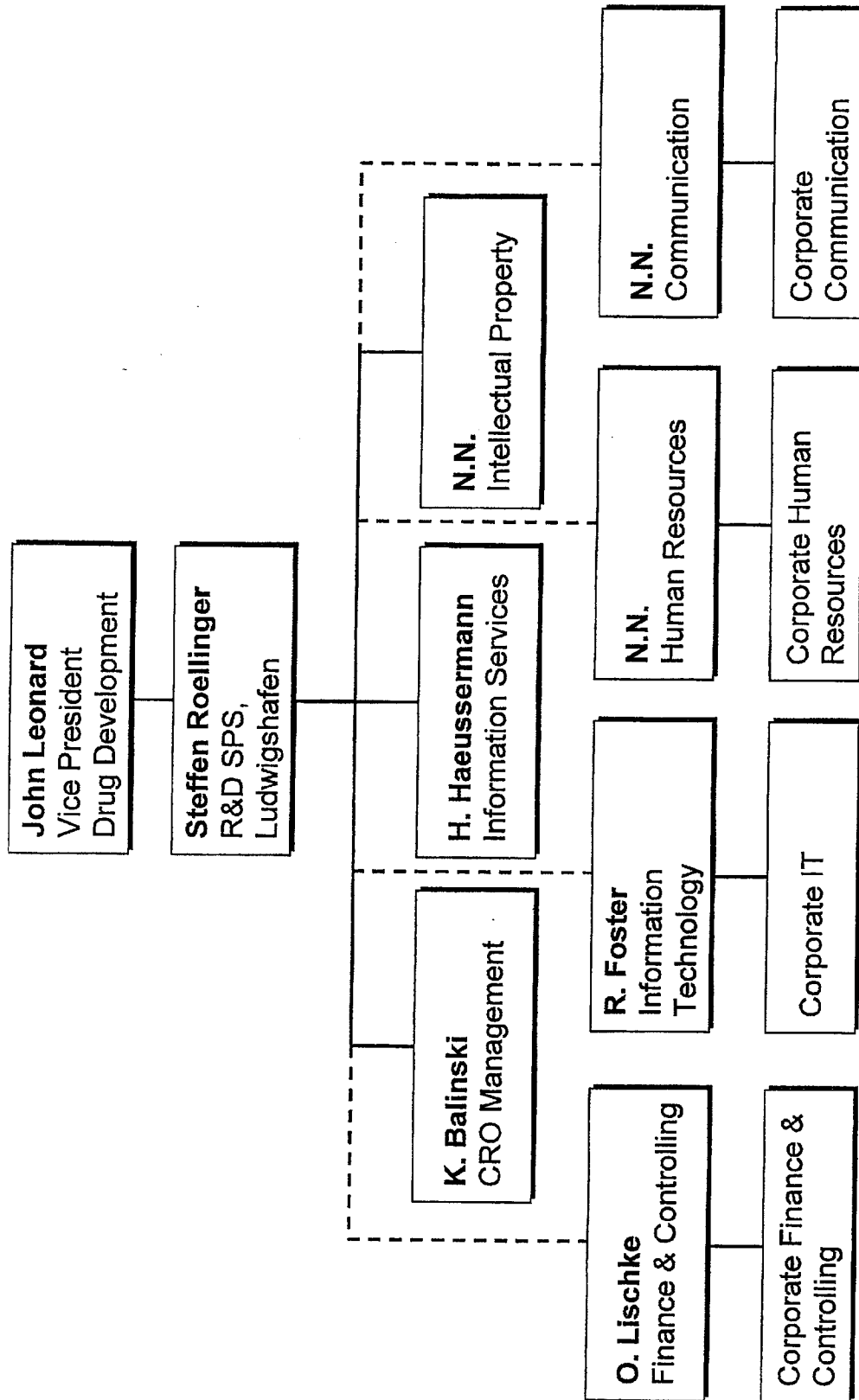
X-KNOLL CLINICAL PHARMACOLOGY (PHASE I)



CH-228011-079jbr/cDC

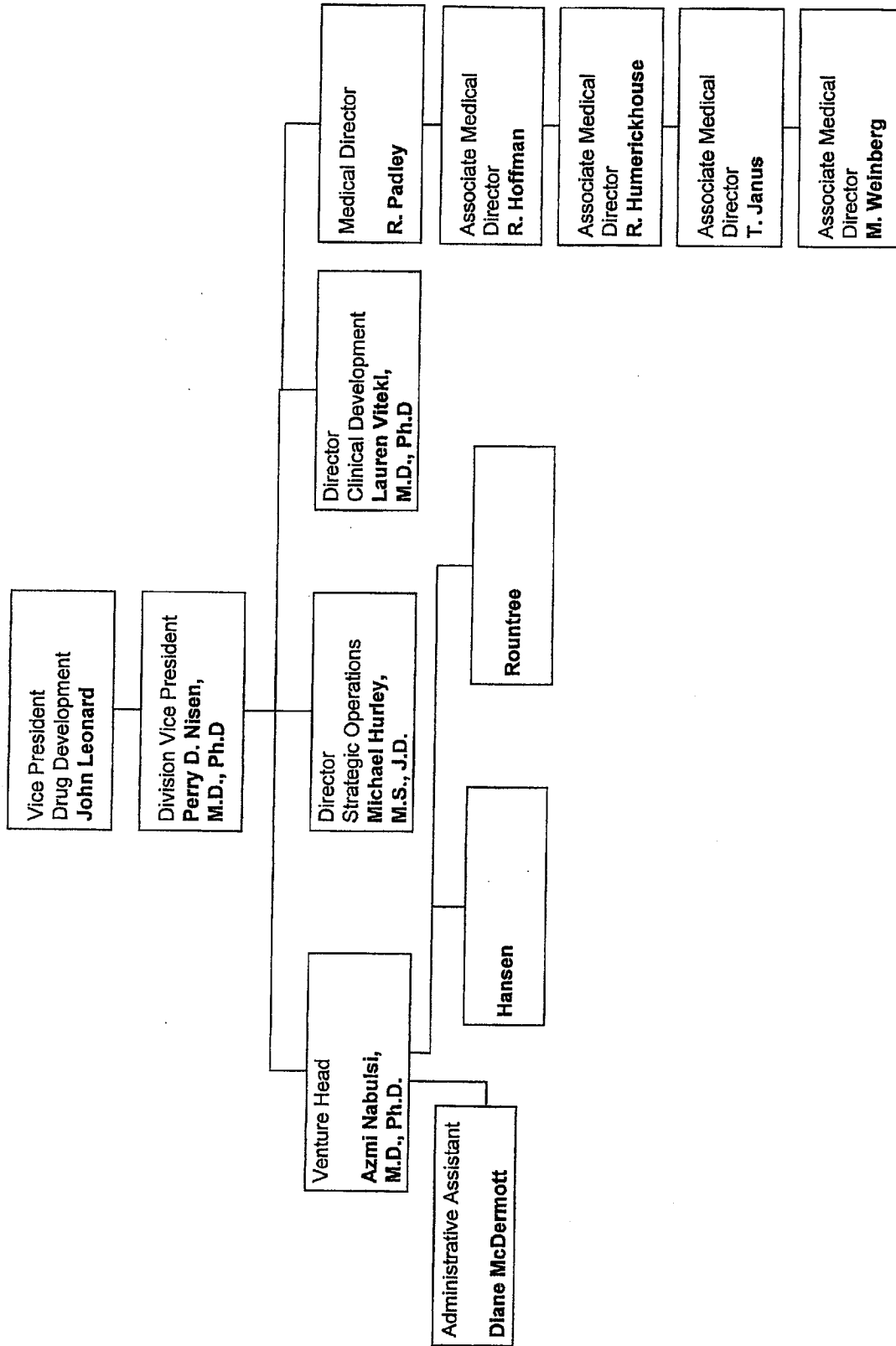
X-KNOLL R&D SYSTEMS, PROCESSES, AND SUPPORT

SEPTEMBER 2000



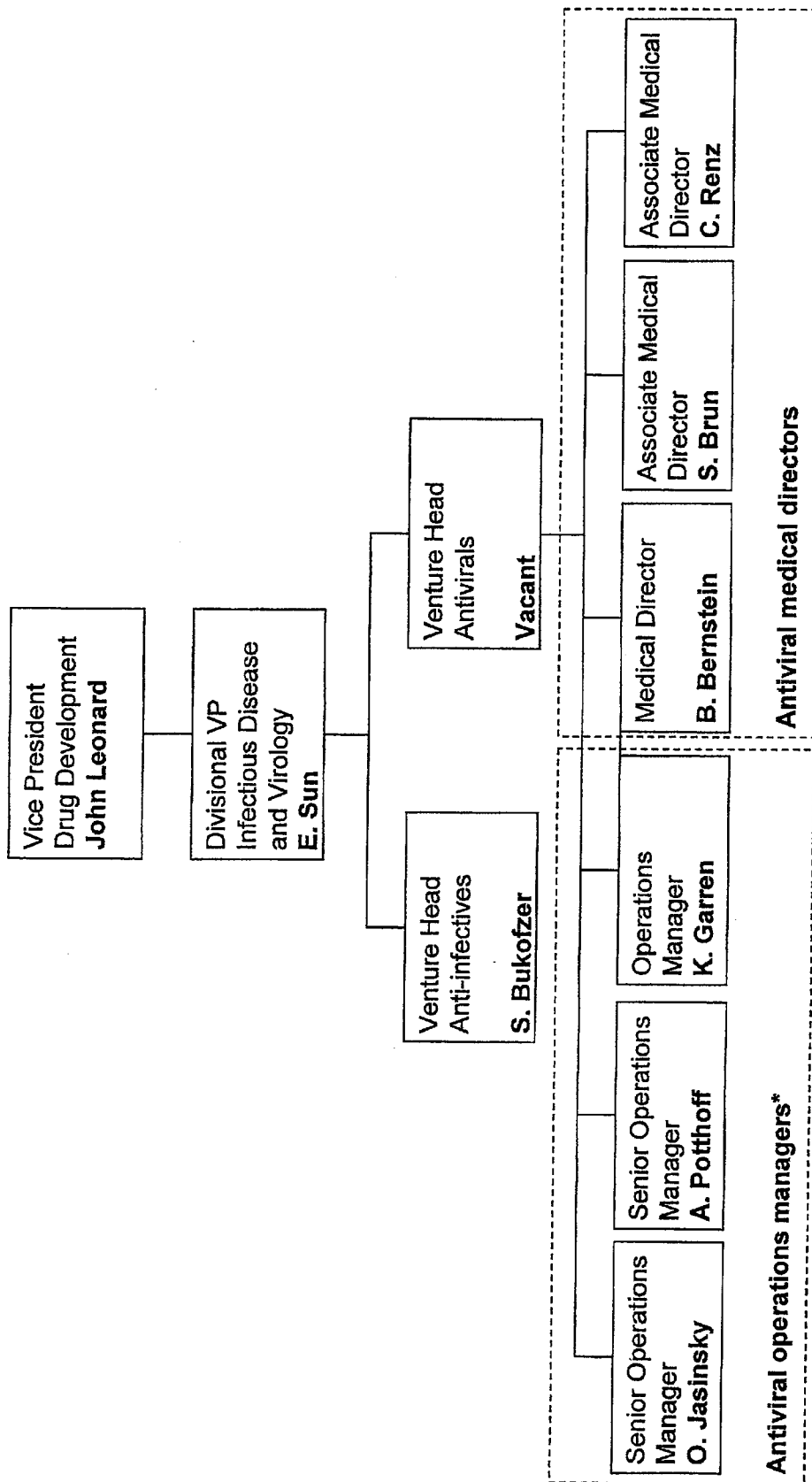
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GLOBAL PHARMACEUTICAL – ONCOLOGY VENTURE ORGANIZATION



CH-228011-079j/rcDC

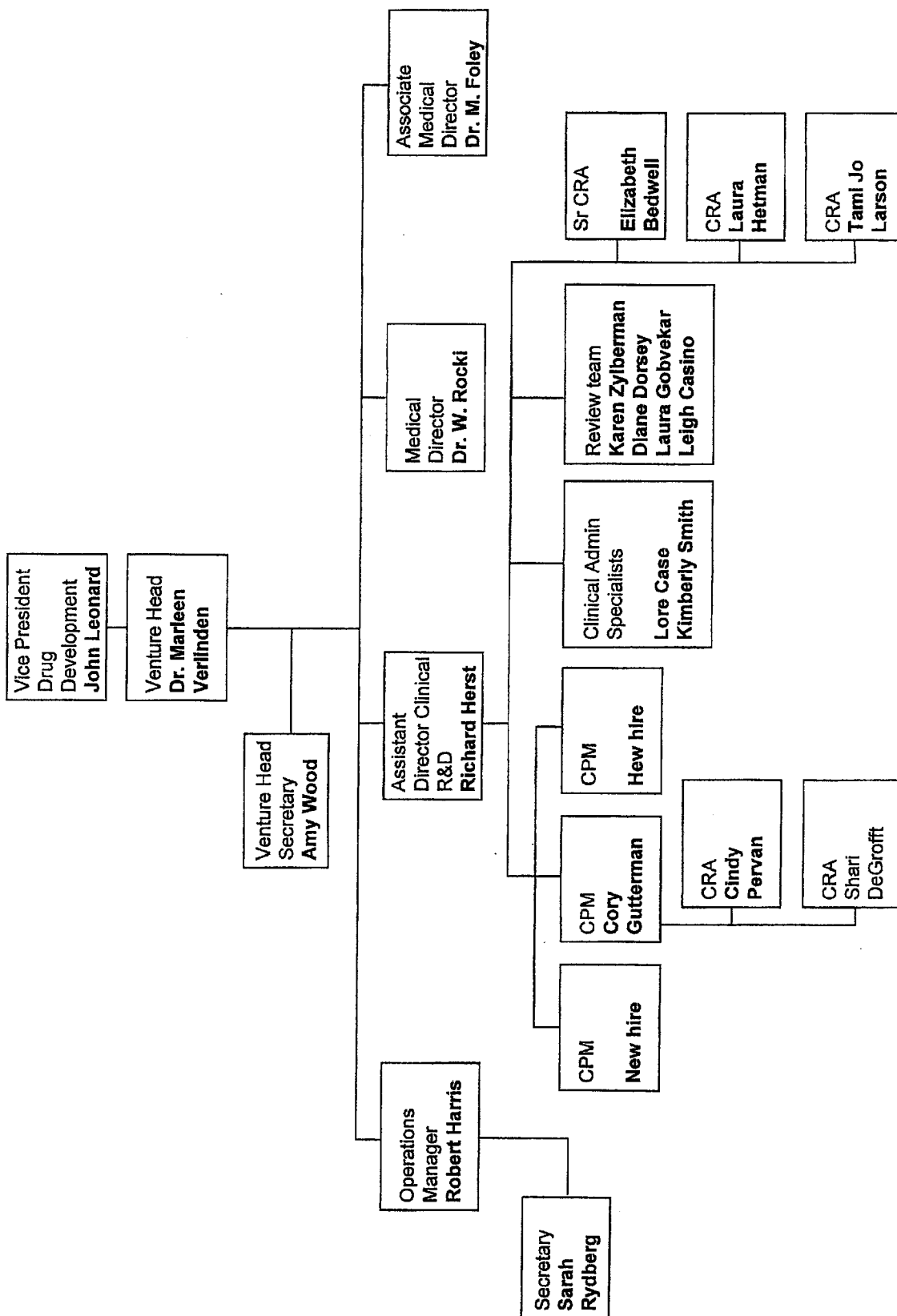
GLOBAL PHARMACEUTICAL – INFECTIOUS DISEASE AND VIROLOGY VENTURES ORGANIZATION



* Direct reports include Clinical Project Managers, Clinical Research Associates (CRAs), and Document Clerks

CH-228011-079jb/rcDC

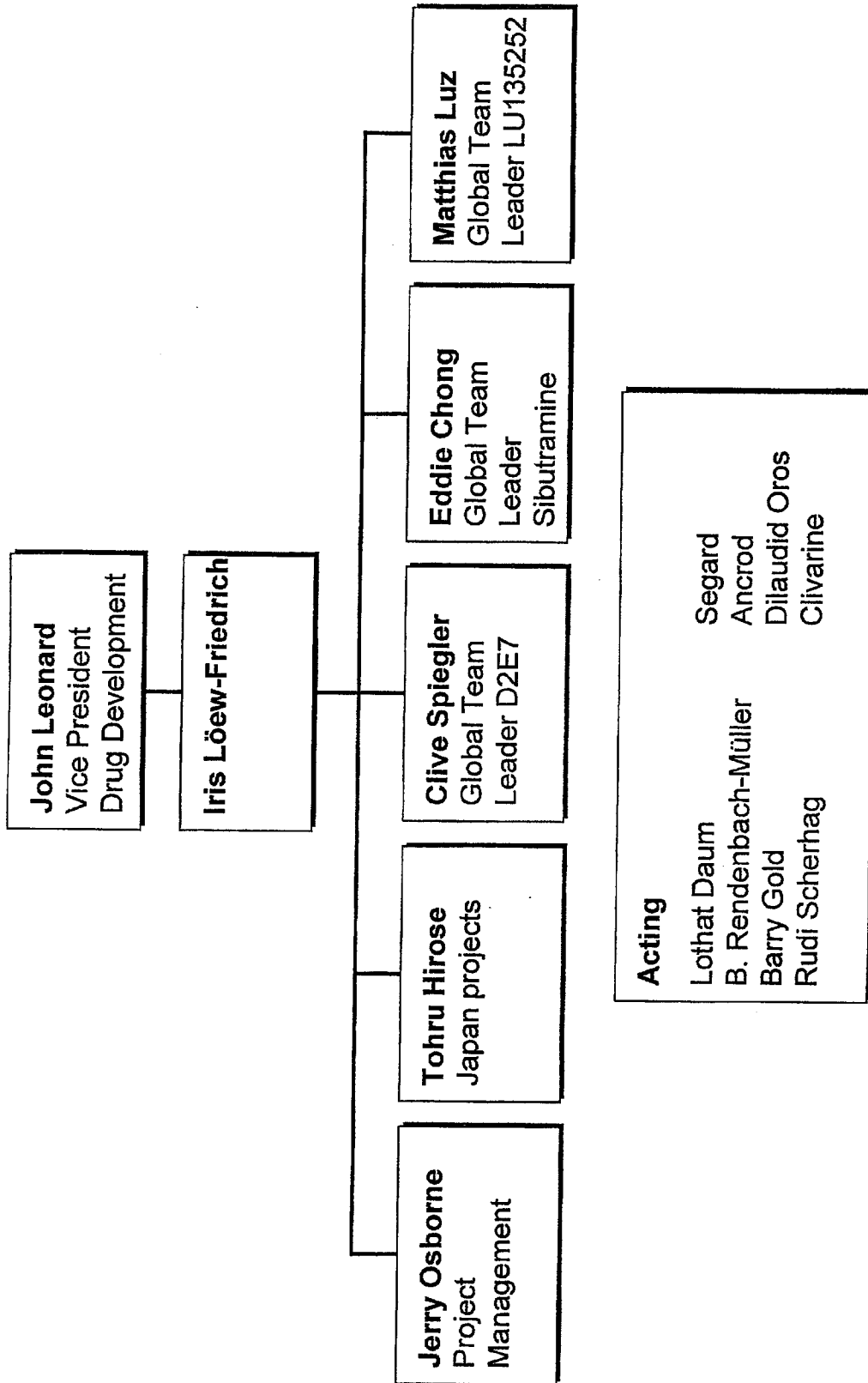
GLOBAL PHARMACEUTICALS – UROLOGY VENTURE ORGANIZATION



X-KNOLL – GLOBAL PROJECTS

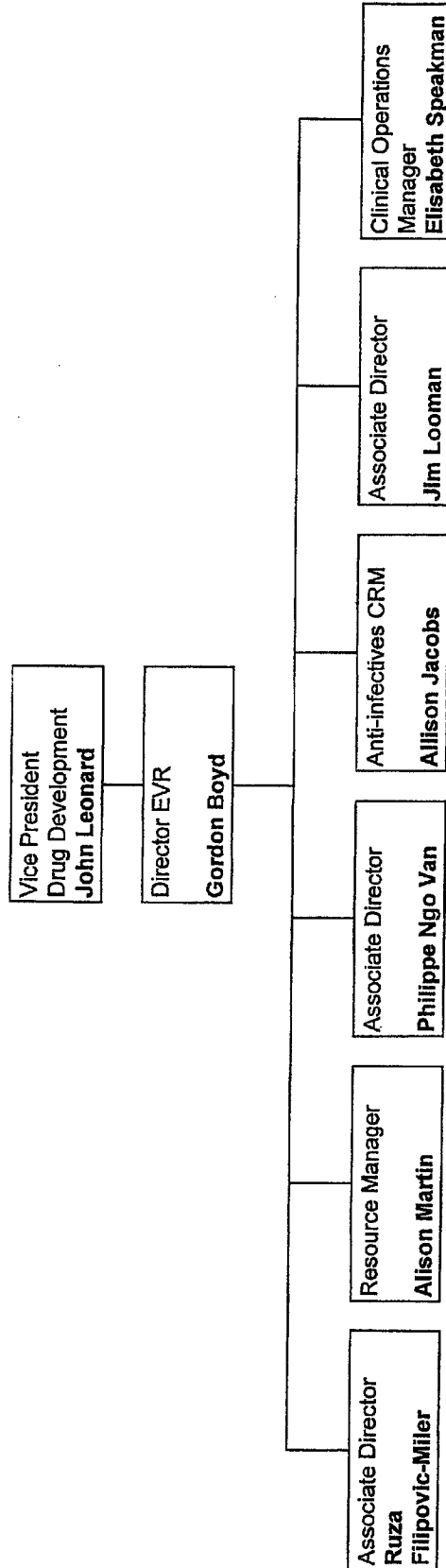
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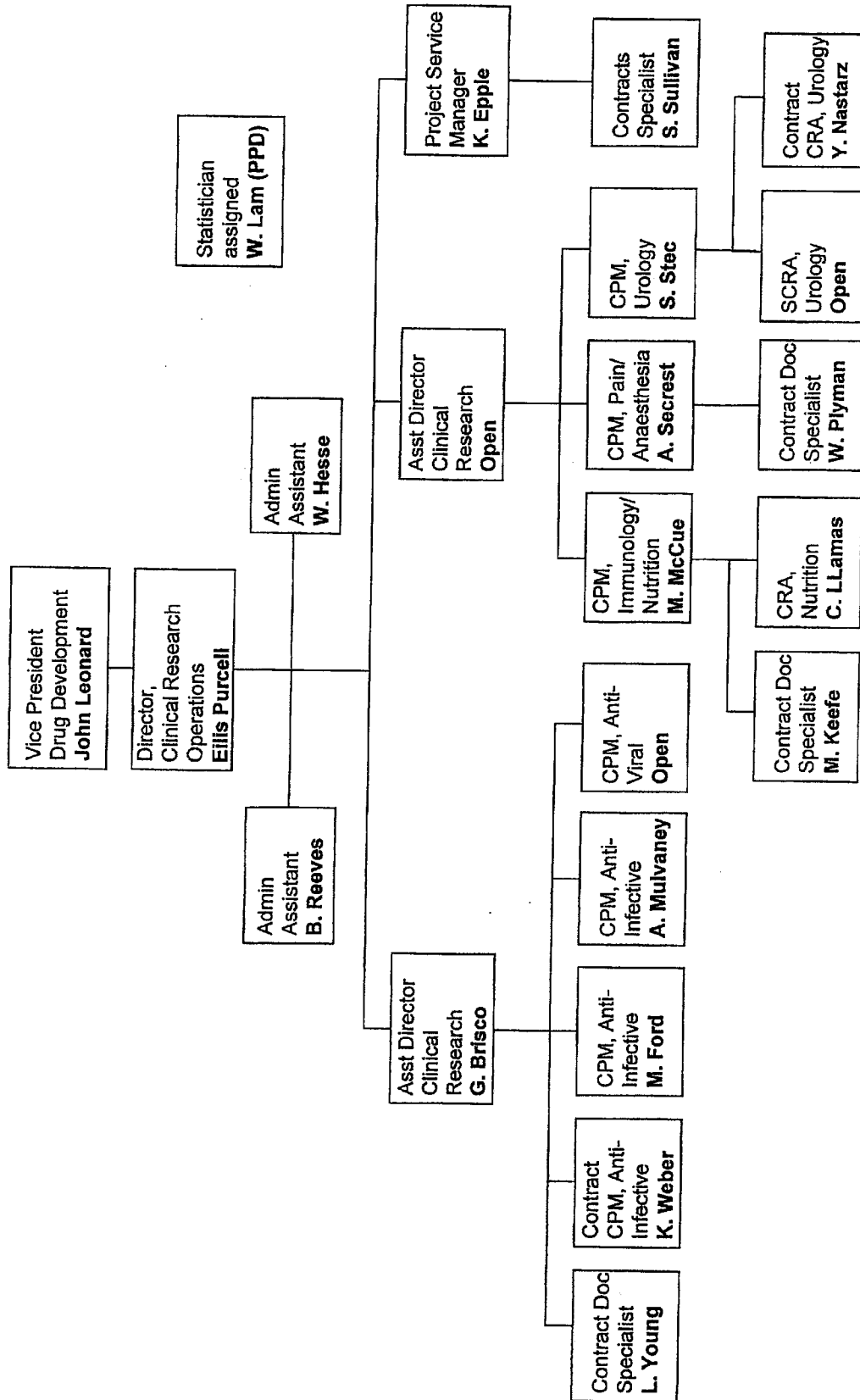
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EUROPEAN VENTURE RESEARCH – ORGANIZATION



CLINICAL OPERATIONS ORGANIZATION

CH-228011-079jbr/dc

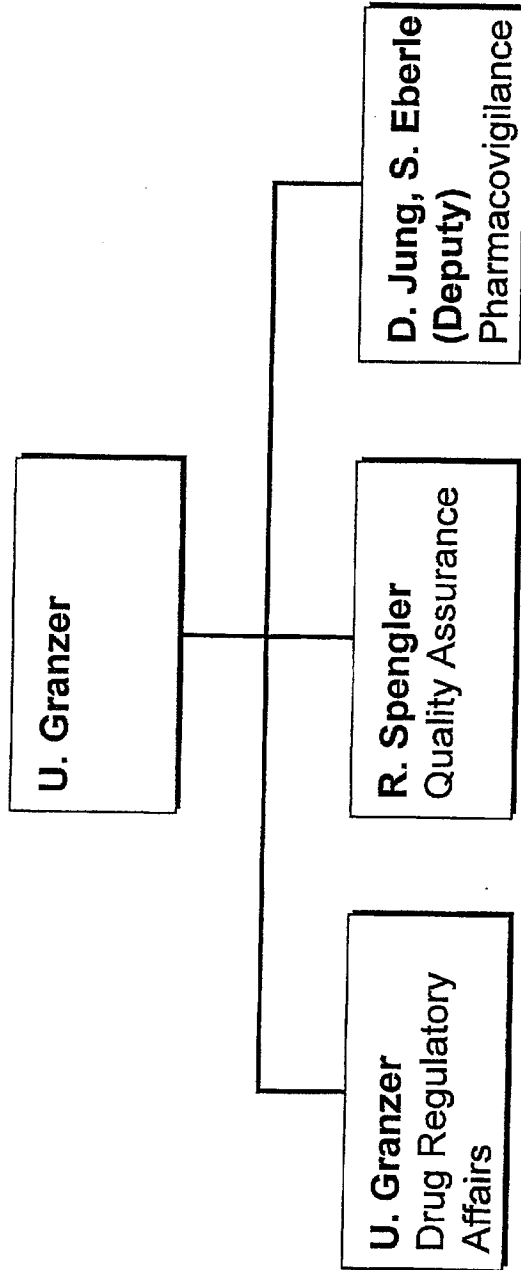


b6
b7C

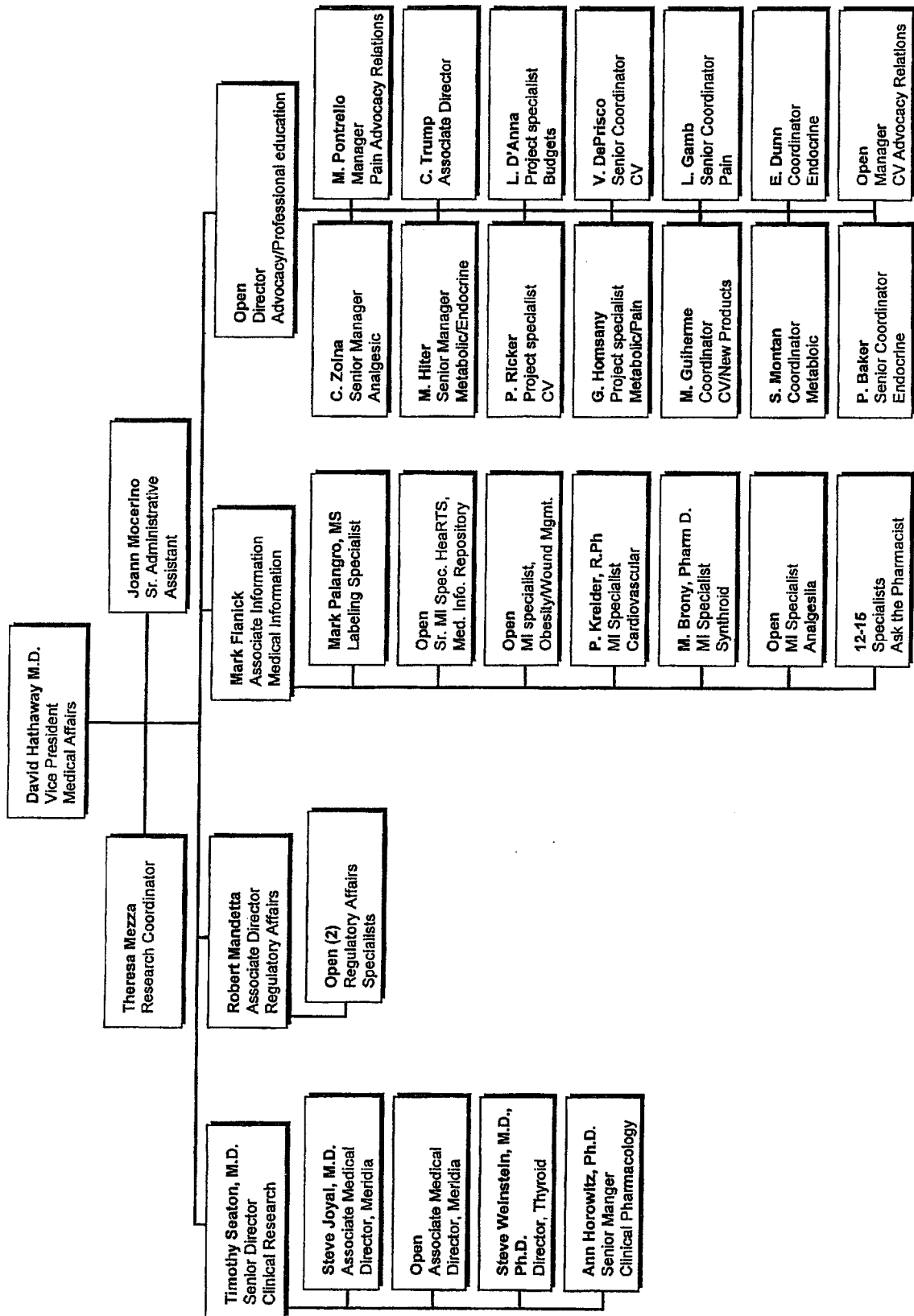
CH-228011-079jb/rcDC

PRE-CLOSE

X-KNOLL REGULATORY CENTERS



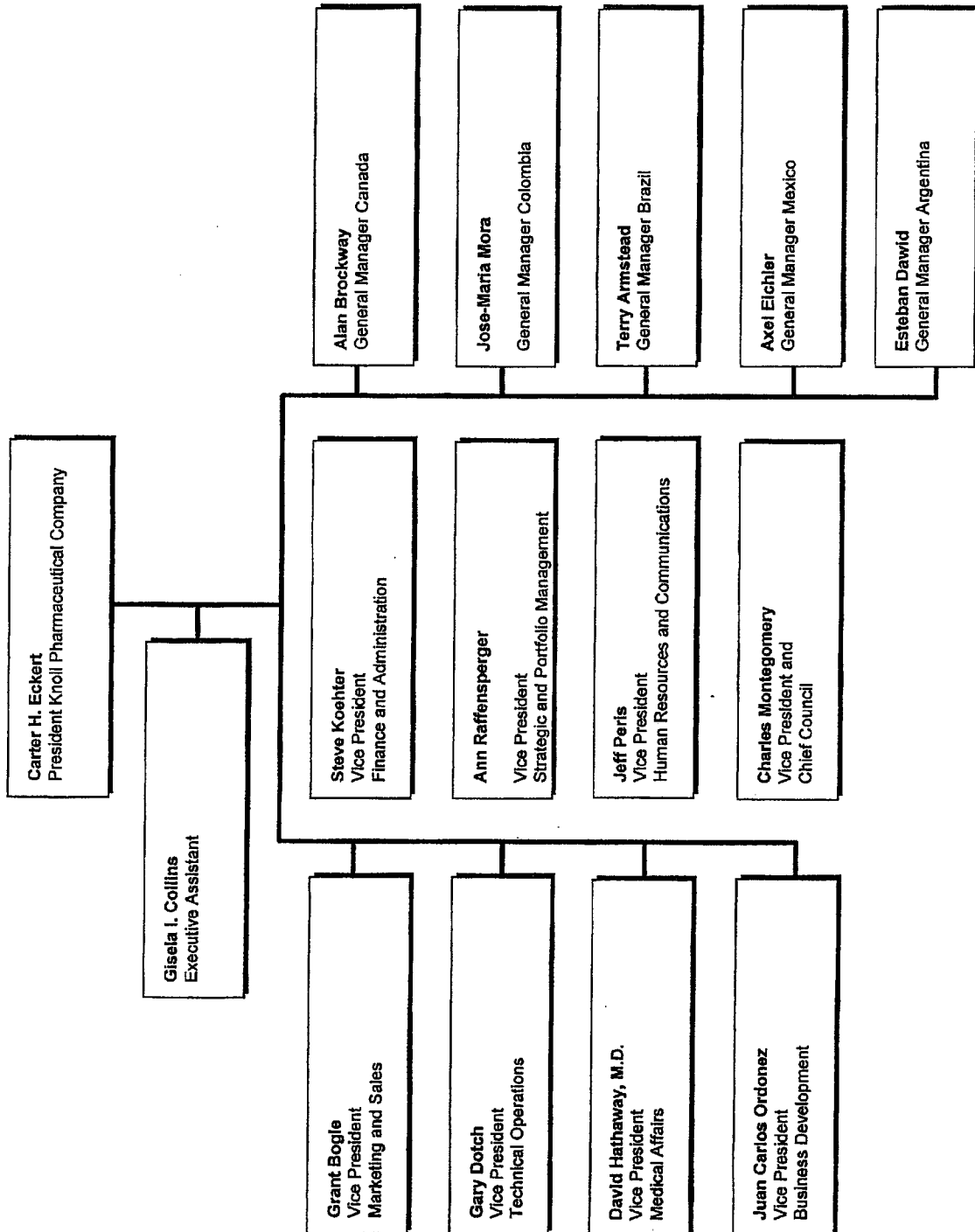
CH-228011-079jb/rcDC

X-KNOLL – MEDICAL AFFAIRS

60

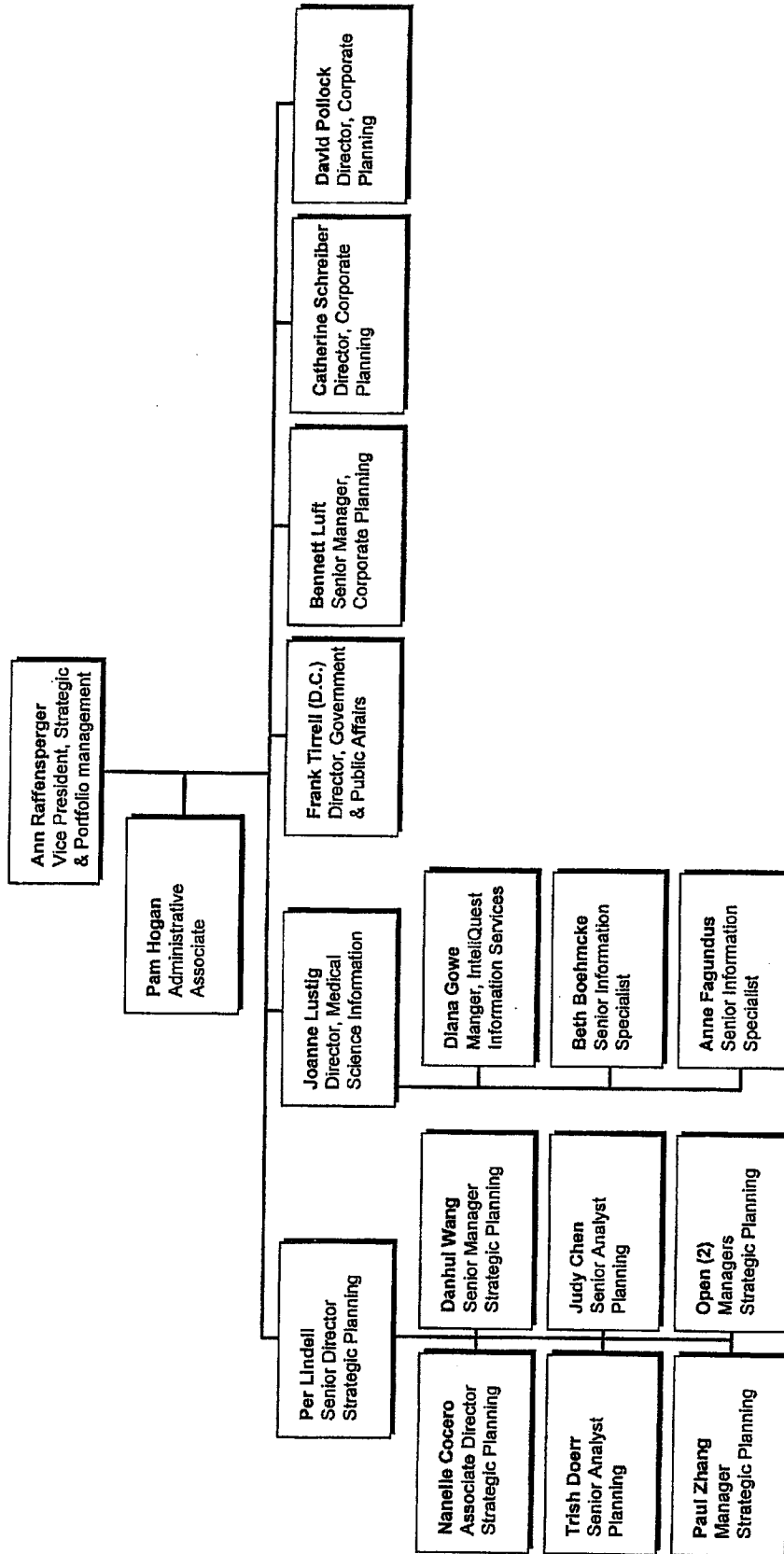
CH-228011-079jb/rcDC

X-KNOLL – AMERICAS PHARMACEUTICAL



CH-228011-079jbr/cdc

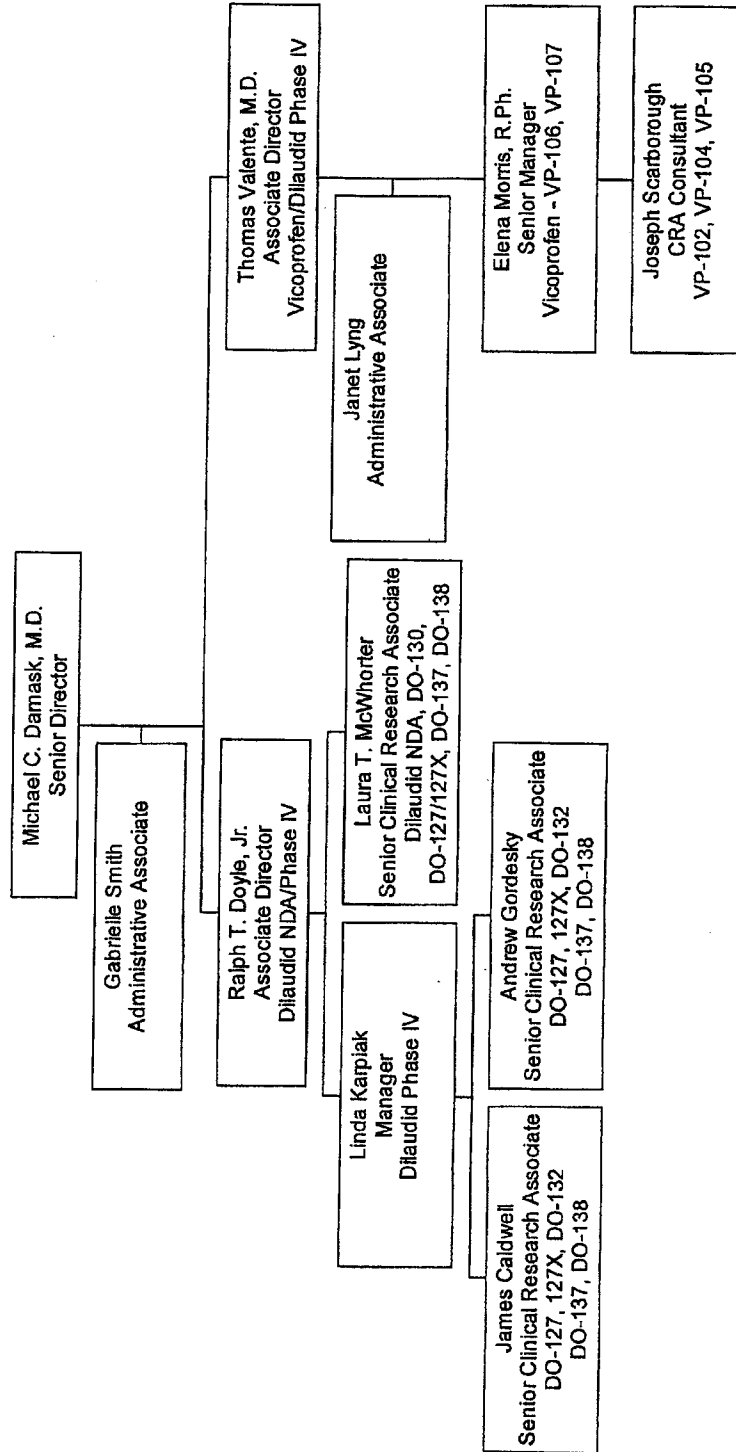
X-KNOLL – STRATEGIC AND PORTFOLIO MANAGEMENT



CH-228011-07gjb/rcDC

X-KNOLL US PHASE IV ACTIVITIES RESIDING IN R&D

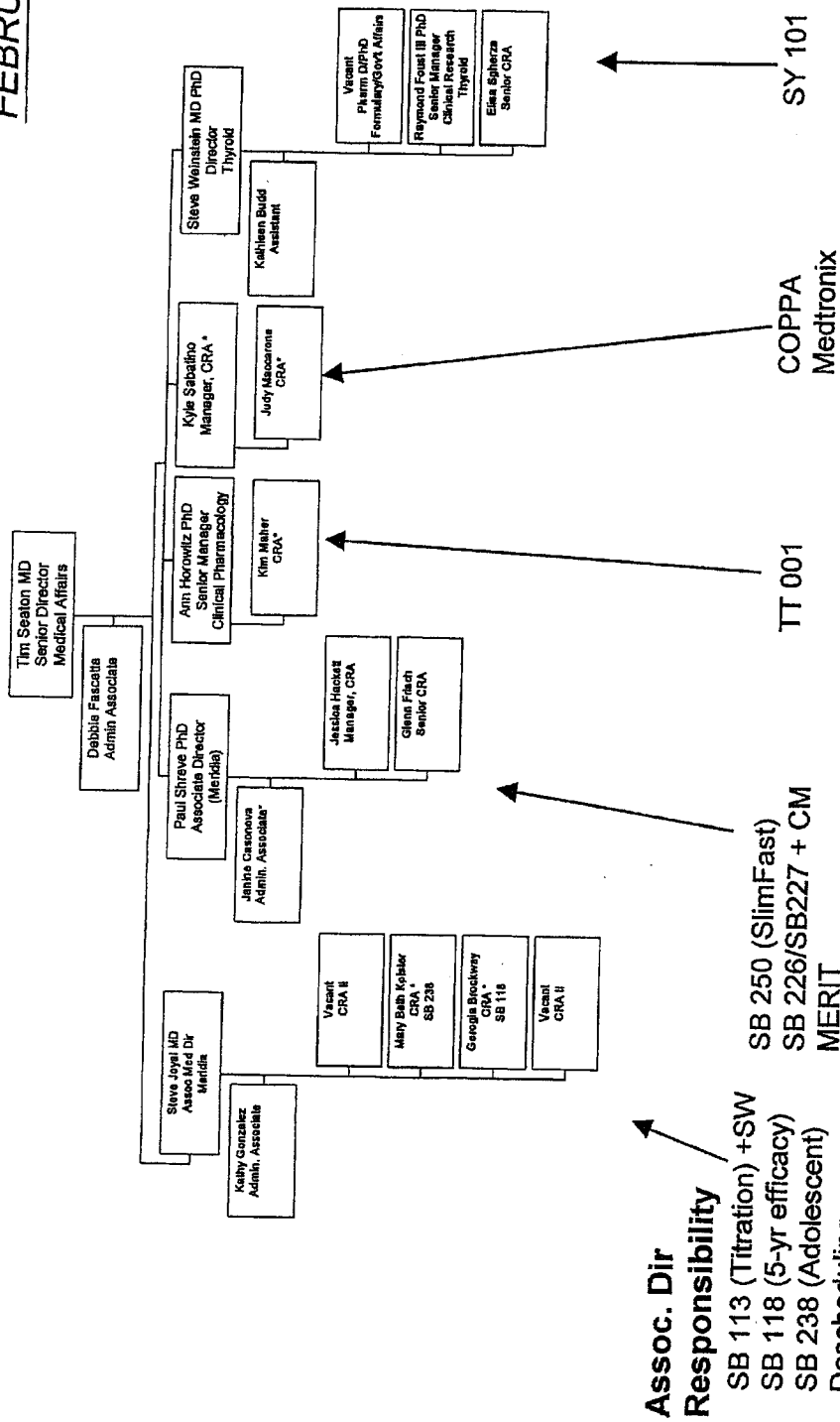
FEBRUARY 2001



CH-228011-079jbr/cdC

X-KNOLL US MEDICAL AFFAIRS ORGANIZATION CHART (WITH CONTRACTORS)

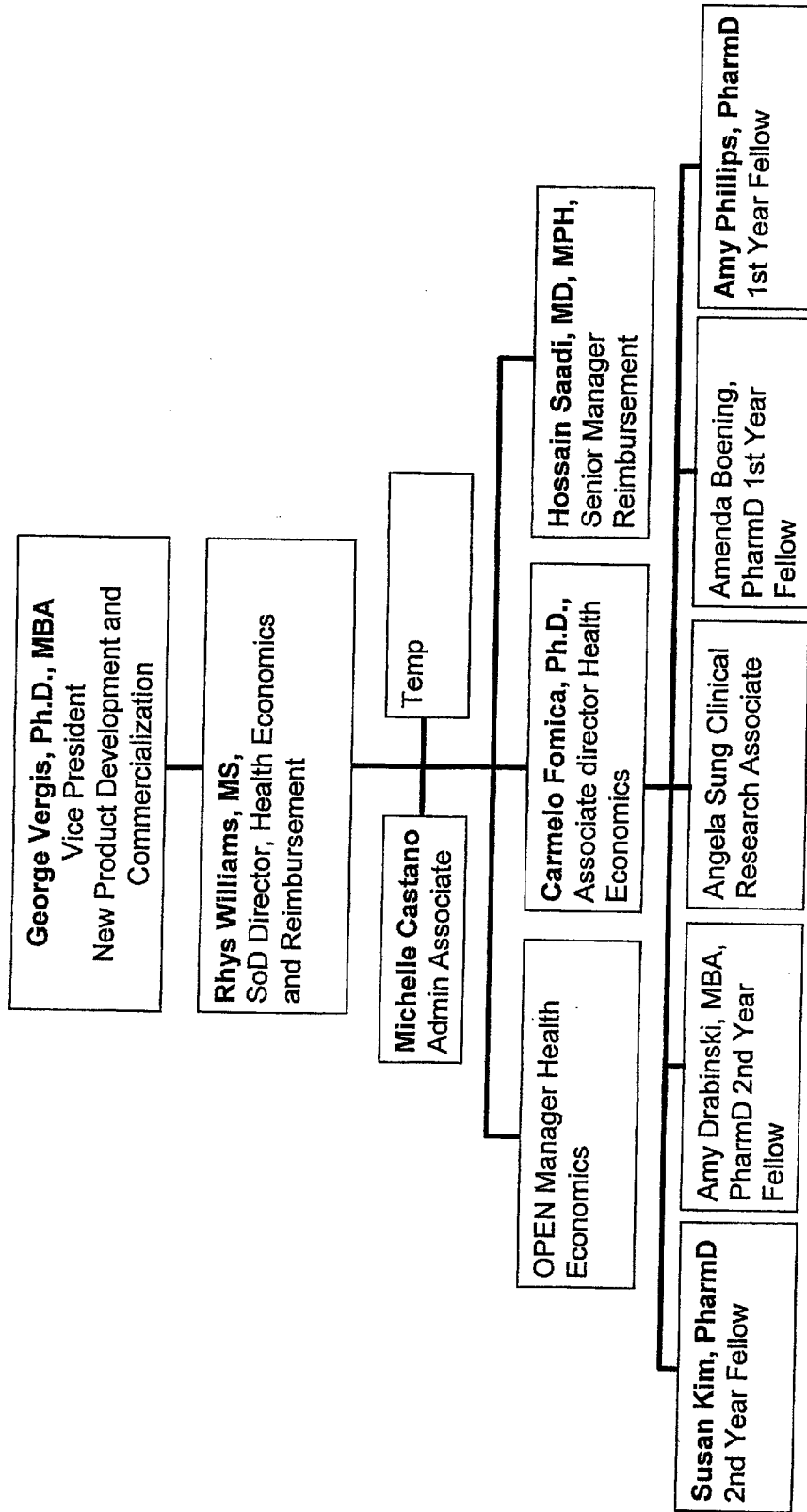
FEBRUARY 2001



CH-228011-079jb/rcDC

X-KNOLL HEALTH ECONOMICS AND REIMBURSEMENT

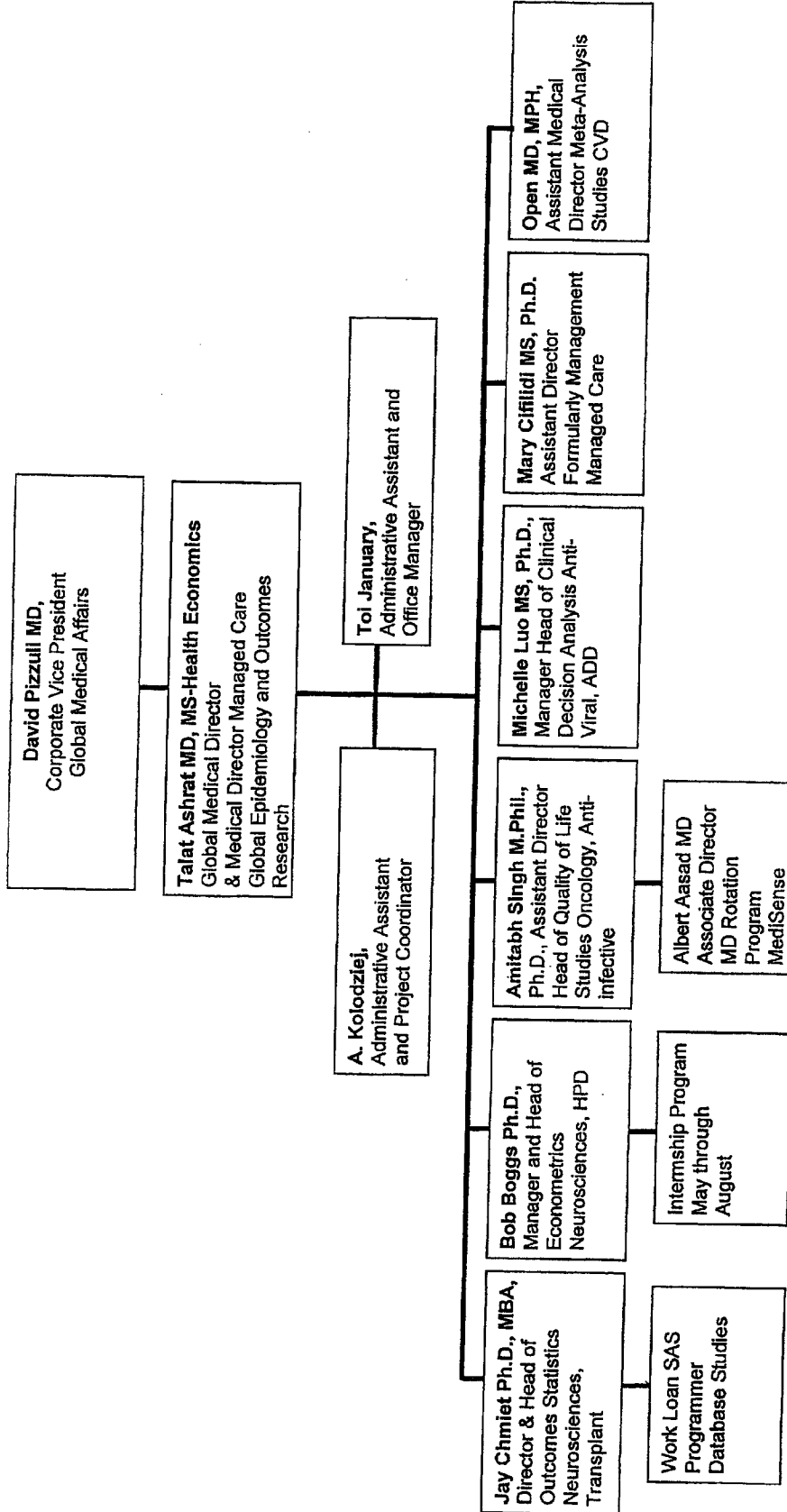
FEBRUARY 2001



* Health economics and reimbursement currently maintains an overhead cost center within new product development and commercialization

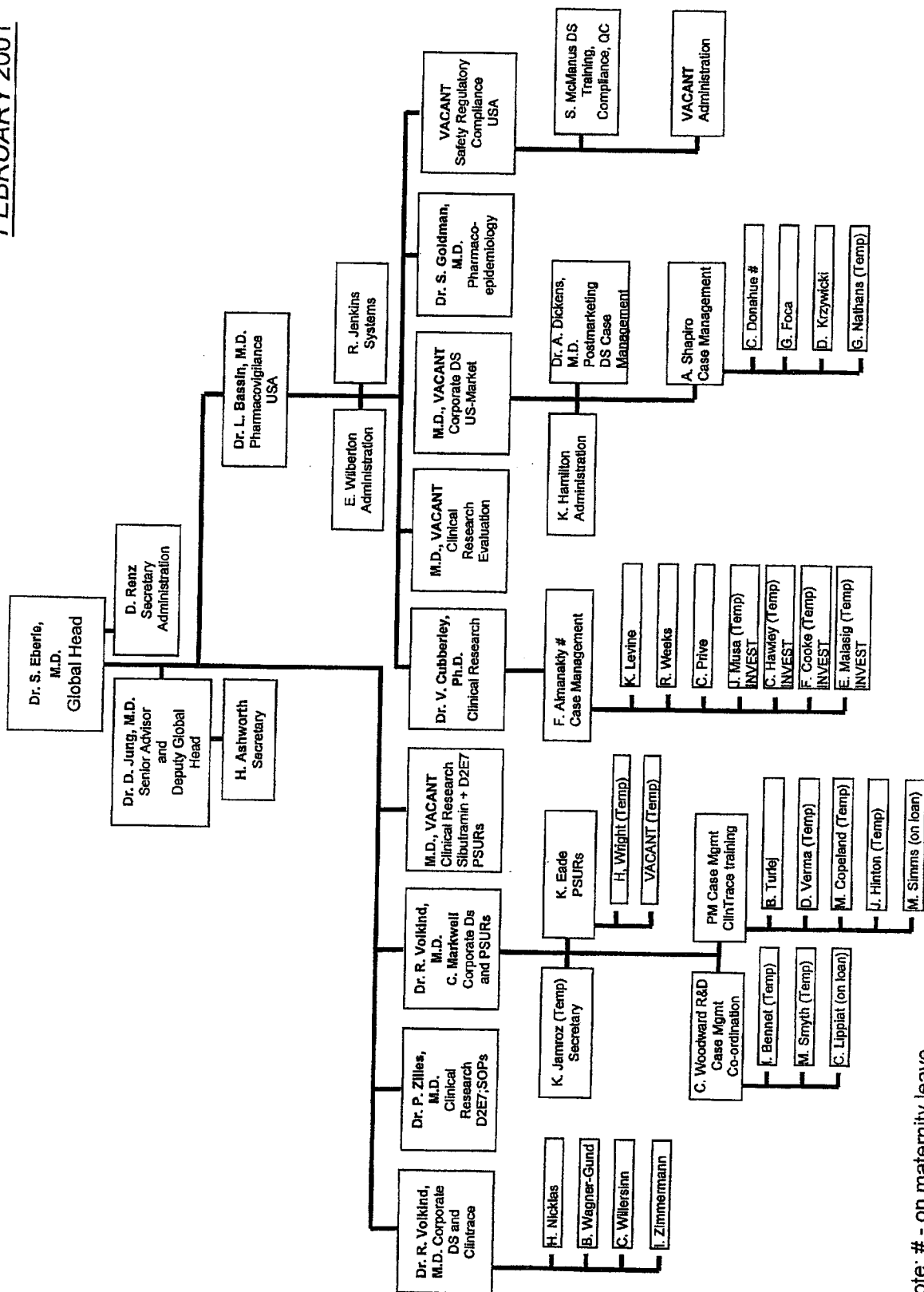
CH-228011-079b/rcDC

ABBOTT GLOBAL EPIDEMIOLOGY AND OUTCOMES RESEARCH



FEBRUARY 2001

X-KNOLL GLOBAL PHARMACOVIGILANCE

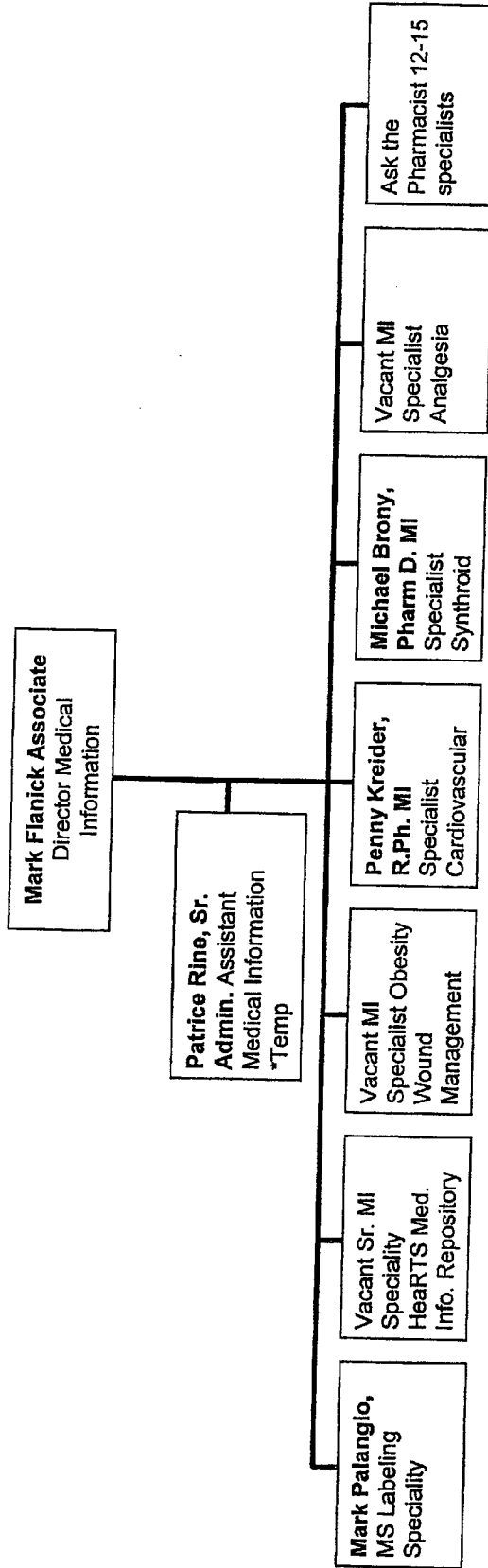


Note: # - on maternity leave

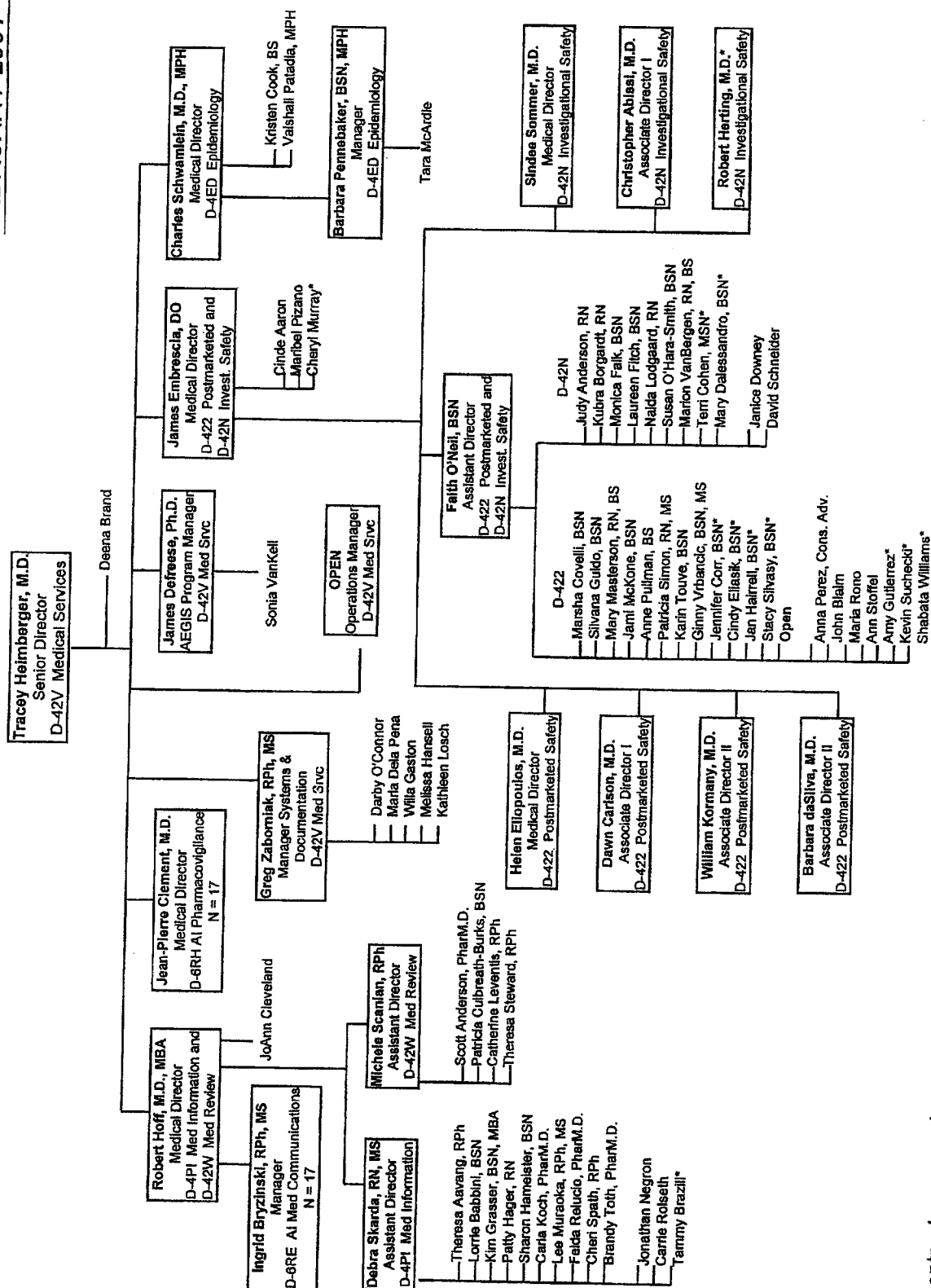
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FEBRUARY 2001

X-KNOLL MEDICAL INFORMATION – U.S.



CH-228011-079jb/rcDC

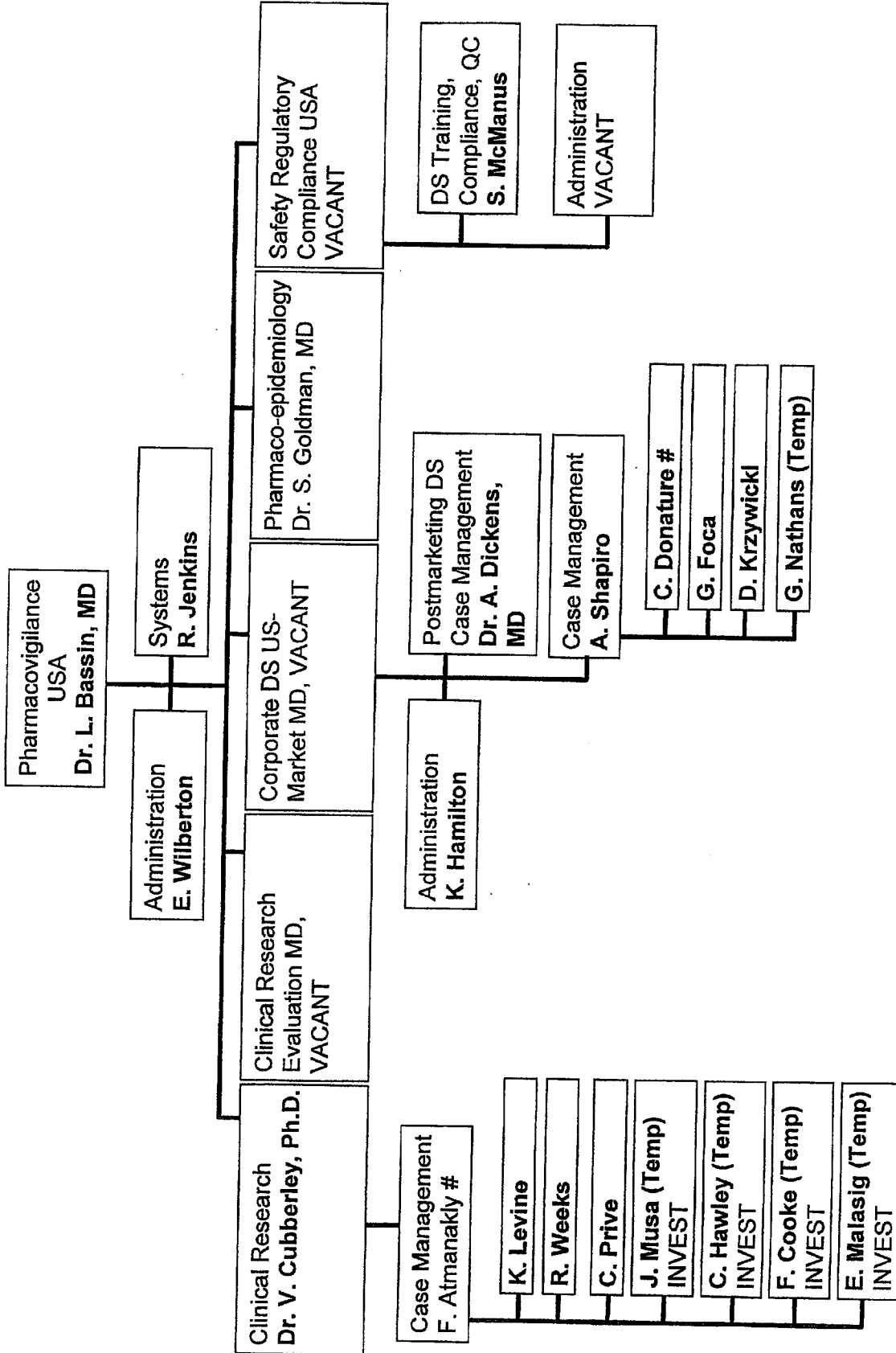
FEBRUARY 2001**ABBOTT MEDICAL SERVICES**

* Contract personnel

CH-228011-079jb/rcDC

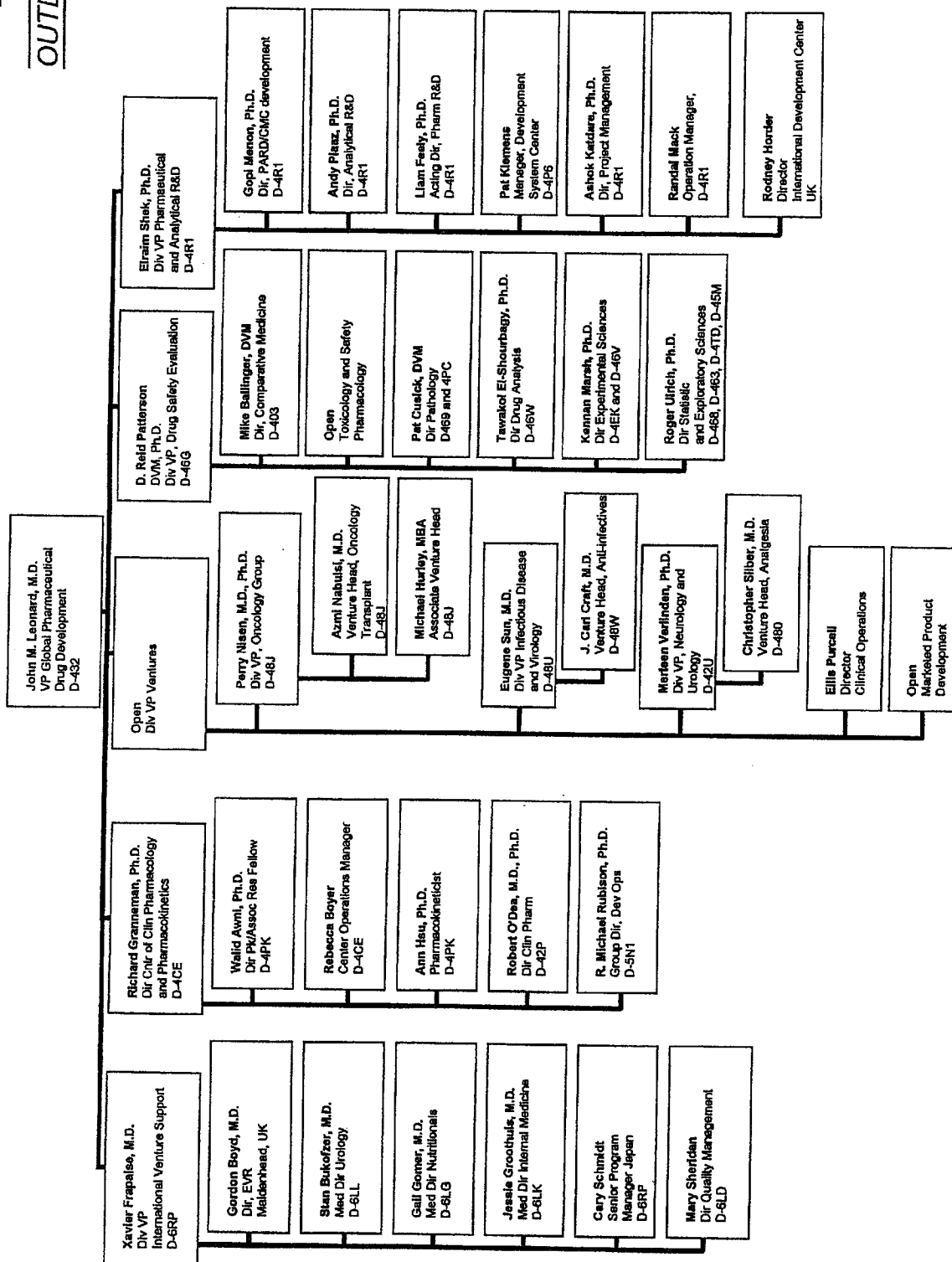
X-KNOLL PHARMACOVIGILANCE – U.S.

FEBRUARY 2001



CH-228011-079jbr/cDC

GLOBAL PHARMACEUTICAL DRUG DEVELOPMENT

DRAFTOUTDATED

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DEPOSITION EXHIBIT 9

PLT'S EXHIBIT FM

Elizabeth
Kowaluk/LAKE/PPRD/ABBO
TT

04/10/2001 04:25 PM

To Keith F Hendricks/LAKE/AI/ABBOTT@ABBOTT, Steve C
Kuemmerle/LAKE/PPRD/ABBOTT@ABBOTT

cc

bcc

Subject Pharma Strategy Retreat on May 2-4

Keith, Steve

Here is the latest from Marleen on the therapeutic area strategy work. As we discussed earlier today, I will continue to work with Marleen and Jim to assist with the R&D inputs to this template, to the extent that it does not interfere with our portfolio work (naturally that comes first). I'd especially like to keep abreast of the Pain project, so that I can pick up the ABT-594 analysis once they are done with this exercise.

Also note the first attachment - this seems to be the final word on therapeutic area designations, and should be helpful for the Portfolio analysis.

Liz

Forwarded by Elizabeth Kowaluk/LAKE/PPRD/ABBOTT on 04/10/2001 04:21 PM



Marleen H Verlinden
04/10/2001 03:19 PM

To: James Sullivan/LAKE/PPRD/ABBOTT@ABBOTT, Bruce McCarthy/LAKE/PPRD/ABBOTT@ABBOTT, Charles McLeskey/HPD/Abbott@Exchange@ABBOTT, John Haden/HPD/Abbott@Exchange, James T Doran/LAKE/HPD/ABBOTT@ABBOTT, Laura Robinson/LAKE/AI/ABBOTT@ABBOTT, Ralf Krauthelmer/KNOLL-AG/BASF@KNOLL-AG, Mike Coghlan/LAKE/PPRD/ABBOTT@ABBOTT, Jorge D Brioni/LAKE/PPRD/ABBOTT@ABBOTT, Damien Springuel/LAKE/AI/ABBOTT@ABBOTT, Elizabeth Kowaluk/LAKE/PPRD/ABBOTT@ABBOTT, Margaret A Foley/LAKE/PPRD/ABBOTT@ABBOTT, Colin Durnin/KNOLL-UK/BASF@KNOLL-UK, Connie Faltynsek/LAKE/PPRD/ABBOTT@ABBOTT, Paul L Bems/NVP/MT-OLIVE/KNOLL-PHARMA/BASF@BASF-CORP, Stan Bukofzer/LAKE/PPRD/ABBOTT@ABBOTT, urodoc@dial.pipex.com @ internet, Robert S Altman/LAKE/PPD/ABBOTT@ABBOTT, Paul L Bems/NVP/MT-OLIVE/KNOLL-PHARMA/BASF@BASF-CORP, Marilou Reed/LAKE/PPRD/ABBOTT@ABBOTT, Nigel Livesey/LAKE/AI/ABBOTT@ABBOTT, John M Leonard/LAKE/PPRD/ABBOTT@ABBOTT, Johan M Baeck/LAKE/AI/ABBOTT@ABBOTT
cc: John M Leonard/LAKE/PPRD/ABBOTT@ABBOTT, Dan W Norbeck/LAKE/PPRD/ABBOTT@ABBOTT
Subject: Pharma Strategy Retreat on May 2-4

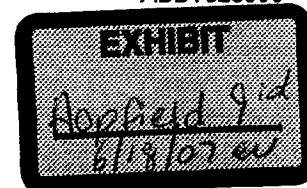
Please find herewith Jeff Leiden's templates for his off site retreat

The direction we receive herewith is quite different from the brief we had received so far. This will necessitate a reorganization of the teams and task assignments. Please look at the templates below.

In view of the extremely short period of time left to do this exercise, I believe it is unrealistic to assume that we can do all of this work collectively, i.e. in the course of "full-team meetings". I suggest for John, Ralf, Paul (analgesia), and for Johan and Bob (Urology) to collect the commercial info via separate meetings of the commercial folks, and for our core team as it existed to date to focus on the medical/clinical/discovery/technical development issues in the templates. The information gathering and preparation of our drafts, each in our respective areas of expertise, will probably take most of the two coming weeks. For the core team, please let's keep our scheduled meetings. I suggest that we clear our calendars completely in the week preceding April 30 and organize a few days

Highly Confidential

ABBT323300



for medical /discovery and commercial to all come together and reconcile the marketing and medical/science templates, if needed, and finalize the presentations. Given the horrendous size of the exercise "in virtual time", do you agree that this approach make sense?

I would like to request that we keep our minds open for new ("scientific franchise") opportunities, -as we were initially briefed-, even if they do not fit in the current franchises, such as for instance a much broader definition of the visceral pain opportunity, spanning over a number of areas that are existing or potentially new for Abbott (e.g. in urology, gastroenterology, analgesia). Let's keep in mind that the brief we got verbally was to not get boxed-in in our thinking, to think about this innovatively, and identify where medical and scientific opportunities may exist now which could bring innovative compounds to market 10 years from now and make us an innovator with a majority of breakthrough, as opposed to follower, compounds. This may require some flexibility in our thinking about the future by venturing outside the currently commercially pre-defined Abbott areas.

John (Leonard), Dan, please advise us if this part of the brief no longer is valid.

Marleen

----- Forwarded by Marleen H Verlinden/LAKE/PPRD/ABBOTT on 04/10/2001 02:24 PM

From: Jeff M Leiden on 04/10/2001 12:27 PM

Sent by: Kathy A Hundley

To: Bruce McNutt/HPD/Abbott@Exchange, Charles McLeskey/HPD/Abbott@Exchange@ABBOTT, David Ostrow/HPD/Abbott@Exchange@ABBOTT, Eugene X Sun/LAKE/PPRD/ABBOTT@ABBOTT, Frank W Zhou/LAKE/Al/ABBOTT@ABBOTT, Fritz-Frieder Frickel/KNOLL-AG/BASF@KNOLL-AG, George Maliekal/HPD/Abbott@Exchange@ABBOTT, Heather L Mason/LAKE/PPD/ABBOTT@ABBOTT, Iris Loew-Friedrich/KNOLL-AG/BASF@KNOLL-AG, James Sullivan/LAKE/PPRD/ABBOTT@ABBOTT, Jerald J Wenker/LAKE/PPD/ABBOTT@ABBOTT, Johan M Baeck/LAKE/Al/ABBOTT@ABBOTT, John Arnott/LAKE/Al/ABBOTT@ABBOTT, John Haden/HPD/Abbott@Exchange, John Toner/HPD/Abbott@Exchange, Lauren V Vitak/LAKE/HPD/ABBOTT@ABBOTT, Mark J Webster/LAKE/PPD/ABBOTT@ABBOTT, Marleen H Verlinden/LAKE/PPRD/ABBOTT@ABBOTT, Mary Szela/HPD/Abbott@Exchange@ABBOTT, Michael Kirchengast/KNOLL-AG/BASF@KNOLL-AG, Loreen Mersheimer/HPD/Abbott@Exchange@ABBOTT, Paul L Berns/NVP/MT-OLIVE/KNOLL-PHARMA/BASF@BASF-CORP, Perry D Nisen/LAKE/PPRD/ABBOTT@ABBOTT, Ralf Krautheimer/KNOLL-AG/BASF@KNOLL-AG, Richard J Marasco/LAKE/PPD/ABBOTT@ABBOTT, Robert I Kamen/NV/WORCESTER/BASF-CORP/BASF@BASF-CORP, Robert S Altman/LAKE/PPD/ABBOTT@ABBOTT, Ronald K Lloyd/LAKE/Al/ABBOTT@ABBOTT, Scott Toner/HPD/Abbott@Exchange@ABBOTT, Shing Chang/LAKE/PPRD/ABBOTT@ABBOTT, Soneil Guptha/LAKE/HPD/ABBOTT@ABBOTT, Steve Fesik/LAKE/PPRD/ABBOTT@ABBOTT, Susan Rodriguez/HPD/Abbott@Exchange, Suzanne Lebold/HPD/Abbott@Exchange@ABBOTT, Terry J Opgenorth/LAKE/PPRD/ABBOTT@ABBOTT, Thomas G Moore/LAKE/HPD/ABBOTT@ABBOTT, Udo Legler/KNOLL-AG/BASF@KNOLL-AG, William Hargan/KNOLL-AG/BASF@KNOLL-AG, Wulff-Erik Von Borcke/NVP/MT-OLIVE/KNOLL-PHARMA/BASF@BASF-CORP

cc: Edward J Fiorentino/LAKE/PPD/ABBOTT@ABBOTT, William G Dempsey/LAKE/Al/ABBOTT@ABBOTT, Arthur J Higgins/LAKE/PPD/ABBOTT@ABBOTT, Dan W Norbeck/LAKE/PPRD/ABBOTT@ABBOTT, John M Leonard/LAKE/PPRD/ABBOTT@ABBOTT, Christopher B Begley [HPDAPP00.BEGLECB]@SSWGATE, Ed Ogunro/HPD/Abbott@Exchange, Steffen Roellinger/KNOLL-AG/BASF@KNOLL-AG, michael_williams@mckinsey.com

Subject: Pharma Strategy Retreat on May 2-4

We are excited about the upcoming Pharma Strategy Retreat on May 2-4. This will be the first opportunity that we will have had to step-back from the integration efforts and take a comprehensive look at the global pharma business we want to build together as part of the new Abbott.

Many of you have already been informed about the therapeutic area

presentations for the retreat. The purpose of this message is to provide you with a more detailed overview of the objectives for the meeting and the criteria that will be used to compare different opportunities. This will be important context as you develop your presentations jointly with your co-chairs.

Retreat objectives

We have three major objectives for the meeting:

1. Gain a shared understanding of the opportunities for Abbott in each therapeutic area.
2. Select our core therapeutic areas for discovery and development moving forward.
3. Within these core therapeutic areas, identify the most important areas for focused discovery, development, licensing and commercial activity.

The goal of this meeting is **not** to finalize R&D project prioritization and budget allocations. However, the work we do together during the three days will be an important input to these decisions, which will be made by May 8th.

Criteria for assessment

As you prepare for your presentation, please use the following criteria to evaluate the opportunities in each therapeutic area.

Major criteria:

1. Chronic diseases with expanding global markets.
2. Scientific opportunity.
3. Unmet medical need.
4. Opportunities for synergies with devices and diagnostics.

Minor criteria:

1. Competitive landscape.
2. Experience and expertise at Abbott.
3. Fit with current marketed products or franchises.
4. Balance of low, medium and high-risk projects across the therapeutic areas.

Meeting agenda, presentations and templates

The final agenda for the meeting will be sent out in the next week. You should assume your presentation should take around 60 minutes, after which there will be approximately 30 minutes of discussion. For anti-infectives, oncology and neuroscience, the presentation time will be expanded to 90 minutes reflecting the breadth of diseases that will need to be addressed.

We have developed the templates for your presentations. These are not meant to restrict your creativity, but rather to ensure sufficient consistency across all of the presentations. Our hope is that you and your co-chairs will jointly act as strong advocates for your areas, focusing on the most important opportunities and challenges of your specific therapeutic area.

To kickoff this effort, a short meeting/conference call will be set up later this week with all of the TA co-chairs, during which I will provide additional context and guidance and address your initial questions. After this, please feel free to contact me directly if you have additional questions.

Attachments: (1) List of TA co-chairs, list of diseases by TA that should be addressed (not inclusive), (2) table of contents for TA presentations, and (3) templates



040901-team and TA lists.ppt 040801-outline for TA presentations.doc



040801-updated templates for R&D update.doc

Regards,

Jeff

SELECTION AND SCOPE OF INDIVIDUAL TA PRESENTATIONS

Ventures/TAs	In-scope areas (not inclusive)
1. Anti-infectives	• Antibacterials, anti-virals, anti-parasitics, antifungals, vaccines
2. Neuroscience	• Stroke, Parkinson's, epilepsy, migraine, Alzheimer's • Psychiatric diseases, Attention deficit disorder
3. Pain/NSAIDS	• Neuropathic pain, chronic pain, NSAIDs • Narcotic analgesia, other analgesia, acute pain
4. Cardiovascular/ thrombosis	• Hypertension, CHF, hyperlipidemia, MI • Stroke, unstable angina, anti-coagulants
5. Urology	• BPH, erectile dysfunction, incontinence
6. Diabetes/obesity/ metabolism	• Diabetes, diabetic complications, obesity, thyroid • All tumors and all pharmaceutical approaches
7. Oncology	• RA/OA, psoriasis, transplantation, MS, Crohn's, sepsis, asthma
8. Immunoscience	• Injectibles, inhalation agents, neuromuscular blockers, anti-emetics, anxiolytics etc
9. Anesthesia	• Vitamin D analogues, erythropoiesis, iron therapy
10. Renal Care	

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TEAMS TO DEVELOP TA PRESENTATIONS

TAs	Co-leaders (joint team)	Other team members*
1. Anti-infectives	<ul style="list-style-type: none"> Clinical - E. Sun - clinical Discovery S. Chang Commercial - Ron Lloyd (AI); Jerry Wenker (PPD) 	• N/a
2. Anti-viral	<ul style="list-style-type: none"> Clinical - E. Sun Discovery - S. Chang Commercial - Frank Zhou (AI); Mark Webster (PPD) 	• n/a
3. Neuroscience	<ul style="list-style-type: none"> Clinical - Iris Loew-Frickel Discovery - J. Sullivan Commercial - Rock Marasco (PPD); J. Arnott to assign (AI) 	• n/a
4. Pain	<ul style="list-style-type: none"> Clinical - M. Verlinden/Charlie McLeskey (HPD) Discovery - Jim Sullivan Commercial - John Heden (HPD); Ralf Krautheimer (AI); Paul Berns (PPD) 	• Commercial Ron Lloyd (AI)
5. Cardiovascular/ thrombosis	<ul style="list-style-type: none"> Clinical - Suneil Gupta (HPD); Iris Loew-Friedrich Discovery - F. Frickel; John Toner (HPD) Commercial - S. Lebold (HPD); Udo Legler and Michael Kirchengast (AI) 	• Commercial - Mary Szela (HPD)
6. Urology	<ul style="list-style-type: none"> Clinical - M. Verlinden Discovery - J. Sullivan Commercial - Johan Baeck (AI); Bob Altman (PPD) 	• n/a

* Co-leaders should broadly leverage expertise from across the Abbott and x-Knoll organizations

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DEPOSITION EXHIBIT 10

PLT'S EXHIBIT FR

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Resource Allocation Across GPRD



Abbott Laboratories

Discussion document

May 5, 2001

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CONTENTS

- Synergy targets and opportunities identified to date
- Potential savings by TA and project in development
- Potential savings by TA and project in discovery
- Functional area and site budgets
- Decision templates
- Appendix

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SUMMARY


- Synergies* of \$63 million required in 2001 and \$79 million in 2002
- Potential synergies of \$64 million already identified
 - \$29 million from R&D sub-teams
 - \$35 million from rationalization of low-rated projects (those rated terminated, hold, or pending) based on development reviews (\$16 million internal, \$19 million external)

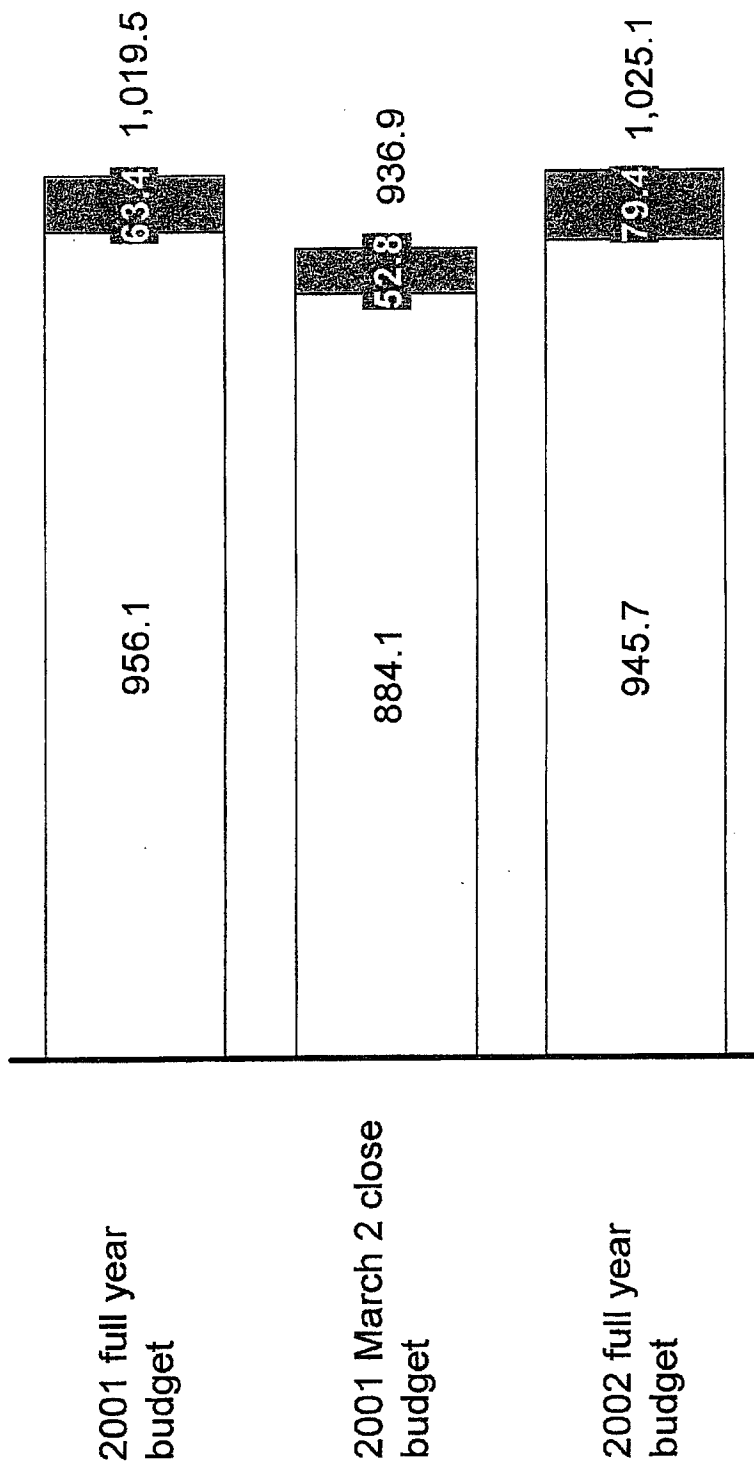
* Excludes affordability

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GPRD BUDGET AND SYNERGY TARGETS

\$ Millions

 Synergy target



Source: GPRD Finance

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SYNERGIES IDENTIFIED TO DATE

Percent; \$ millions

PRELIMINARY

	Percent of 2001 target achieved	Target 2001	Synergies		Cumulative headcount reductions	
			2001	2002	2001	2002
Regulatory affairs / QA	180	0.5	0.9	1.9	7	7
Data manage- ment / statistics	173	1.5	2.6	2.8	38	38
Medical affairs	120	1.5	1.8	3.4	26	26
CMC	105	10.0	10.5	21.6	207	184
IM&T	103	3.0	3.1	5.1	6	6
Phase I	100	1.0	1.0	2.5	7	8
Other (admin., etc)	100	2.0	2.0	3.3	0.2	0.2
Venture/global team management	100	4.5	4.5	8.9	93	93
Drug safety	70	3.0	2.1	3.6	15	15
Discovery	23	3.0	0.7	4.2	29	29
Total	97	30.0	29.2	57.3	430	408

Source: Synergy templates submitted by sub-teams

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DESCRIPTION OF SYNERGIESPRELIMINARY

Function	Key initiatives
Data management/statistics	<ul style="list-style-type: none"> • Reduce head count globally, especially in Mt. Olive • Insource planned contracted work for Phase IV studies
Medical affairs	<ul style="list-style-type: none"> • Reduce global head count in marketed product development • Consolidate medical information personnel • Reduce health outcomes personnel in Ludwigshafen
CMC	<ul style="list-style-type: none"> • Close chemical plant in Ludwigshafen • Exit all CMC activities at Whippy and Italy • Eliminate redundancies in PARD, PPD clinical packaging, and PPD QA • Increase formulation activities at Ludwigshafen
IM&T	<ul style="list-style-type: none"> • Cancel emerging dossier projects • Reduce U.S. R&D IT infrastructure costs
Phase I	<ul style="list-style-type: none"> • Increase utilization of Waukegan and Ludwigshafen Phase I units through right of first refusal for studies • Reduce head count globally
Other (Admin., etc.)	<ul style="list-style-type: none"> • Consolidate services purchased
Regulatory affairs/QA	<ul style="list-style-type: none"> • Reduce global head count and operating expenses
Venture/global team management	<ul style="list-style-type: none"> • Reduce head count in Mt. Olive and Canada • Optimize resources and internalize work
Drug safety	<ul style="list-style-type: none"> • Reduce external costs by shifting contracted work in Europe to Abbott Park • Consolidate radiochemistry at Abbott Park
Discovery	<ul style="list-style-type: none"> • Consolidate high throughput screening at Abbott Park

Source: Synergy templates submitted by sub-teams

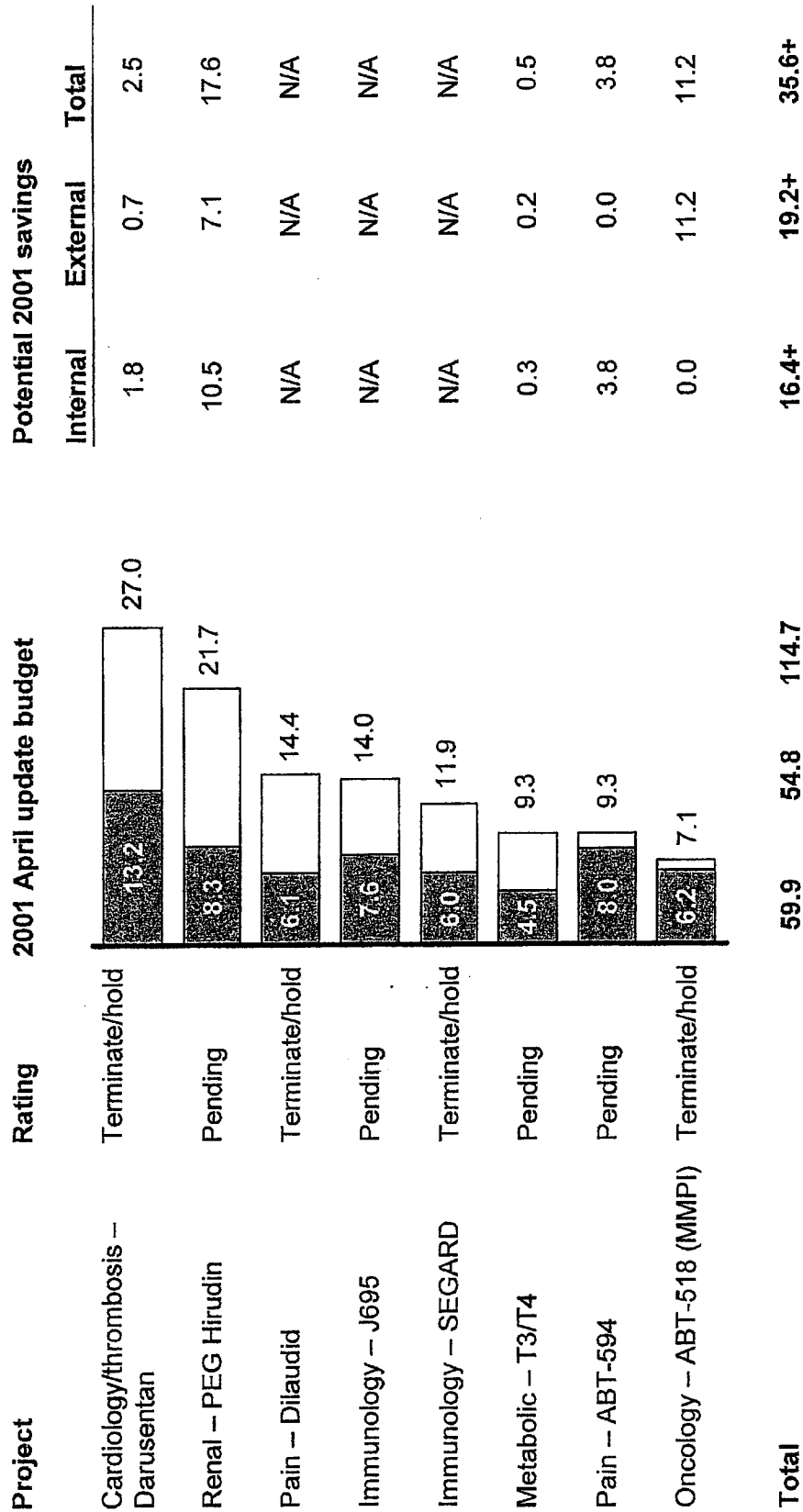
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POTENTIAL SAVINGS FROM LOW-RANKED PROJECTS

\$ Millions

PRELIMINARY

☐ External
☒ Internal



Note: Expected 2002 budget is \$179.3 million

Source: GPRD Finance; development review

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INITIAL PORTFOLIO PRIORITIZATIONC- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Anti-infectives ABT-492	C	<ul style="list-style-type: none"> • Address safety issues (including QTc) with internal/ expert review • Determine how many indications at launch (pay back) 	• J. Leonard	-
HSR-903	T	<ul style="list-style-type: none"> • Consider trading with Daiichi • Halt any new expenditure 	• J. Tyree	-
ABT-773	C	<ul style="list-style-type: none"> • Assess side effects issues with expert review (QTc and liver tox.) • Ensure all drug interactions are adequately covered • Assess relative to Ketek 	<ul style="list-style-type: none"> • J. Leonard • J. Leonard • I. Loew-Friedrich 	-
Urology BSF 420627	P	<ul style="list-style-type: none"> • Set up task force to address issues and bring back plan to senior management <ul style="list-style-type: none"> - Reasons for failure of the SKB ETa/b antagonist - Design short (~4 week) PoP trial for symptom relief - Rationale for sustained release formulation - Nature of the Schwarz Pharma relationship 	• J. Leonard	• By May
Hypothyroidism T3/T4	P	<ul style="list-style-type: none"> • Assess most appropriate ratio • Gain FDA feedback on study design • Determine ex-US market attractiveness (price) 	• J. Leonard	• By May
Asthma Hokunalin tape	P	<ul style="list-style-type: none"> • Conduct market research on acceptance by different patient segments • Determine how to position against long acting beta agonists and combination inhalers • Evaluate opportunity to gain complete access to the patch technology 	<ul style="list-style-type: none"> • A. Higgins/ E. Fiorentino • J. Tyree 	• May

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Oncology ABT-510	C	<ul style="list-style-type: none"> Pursue proof of concept Leverage TAP knowledge of angiogenesis product development (appropriate endpoints) 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> As planned
ABT-751	C	<ul style="list-style-type: none"> Pursue proof of concept Use echocardiogram to monitor potential cardiotoxicity Resolve potent drug manufacturing approach 	<ul style="list-style-type: none"> Project team CMC group Senior management 	<ul style="list-style-type: none"> As planned
ABT-518	Hold/T	<ul style="list-style-type: none"> Wait for May results from Pfizer (will save ~\$1mill) and re-evaluate Halt all further expenditure 	<ul style="list-style-type: none"> Senior management 	<ul style="list-style-type: none"> May
Rubitecan	P	<ul style="list-style-type: none"> Significant clinical rework required (funded by partner)- further in-depth review required Make a proceed decision when 2Q data available 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> By May
Theragyn	P	<ul style="list-style-type: none"> Negative initial scientific perspective - further in-depth review required, e.g., <ul style="list-style-type: none"> Determine if there is a PoC to support claim Address GMP issues Determine best control to demonstrate efficacy Re-look at partnership contract 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> By May
ABT-627	C	<ul style="list-style-type: none"> Seek alternative funding (e.g., NCI) before starting major trial If move ahead <ul style="list-style-type: none"> Determine how to ensure NDA filing in 2004 Get FDA input since survival not primary endpoint Harmonize US and EU study design and inputs Consider partnership (e.g., BI or established oncology player) 	<ul style="list-style-type: none"> J. Tyree J. Leonard, P. Nisen 	<ul style="list-style-type: none"> By May ASAP

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Cardiology/ thrombosis Darsentan (LU 135252)	Hold/T	<ul style="list-style-type: none"> Continue currently budgeted funding for next 6 months Do not start any new trials (e.g., hypertension planned for May) Consider out-license or swap 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> Ongoing
LU 208075	Hold/T	<ul style="list-style-type: none"> Continue currently budgeted funding for next six months Look at Myogen deal Out-license or swap 	<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> ASAP
Levosimendan	C	<ul style="list-style-type: none"> Conduct detailed expert panel review for trial design 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> May
PEG-hirudin	P	<ul style="list-style-type: none"> Set up expert panel for commercial assessment (is diabetes an option?) 	<ul style="list-style-type: none"> E. Ogunro 	<ul style="list-style-type: none"> By May
Ancrod	T	<ul style="list-style-type: none"> Identify out-licensing opportunities 	<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> TBD
Urokinase	P	<ul style="list-style-type: none"> Market research required on open cath Match versus IPA in dose-ranging studies to determine efficacy 	<ul style="list-style-type: none"> E. Fiorentino 	<ul style="list-style-type: none"> By May
Pro-urokinase	C	<ul style="list-style-type: none"> Identify opportunities to speed up program 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> TBD
Cilvarine	C	<ul style="list-style-type: none"> Assessment by HPD (review previous evaluation and new trial data) Understand finished product manufacturing cost 	<ul style="list-style-type: none"> E. Ogunro 	<ul style="list-style-type: none"> By May
Rythmol SR	C	<ul style="list-style-type: none"> Continue filing Verify if package is likely approvable Assess commercial attractiveness in a generic market 	<ul style="list-style-type: none"> B. Dempsey 	<ul style="list-style-type: none"> Ongoing

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Neuroscience				
ABT 594	P	<ul style="list-style-type: none"> • Await results from ongoing PII trial – probable T • Project team to develop decision criteria for go/no go 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • June/ July
ABT 963	C	<ul style="list-style-type: none"> • Identify a co-development/co-promotion partner (TAP high on list) • Evaluate benefits of the long half life in pain and cancer (including additional physician market research) • Explore cancer prophylaxis and Alzheimer's indications 	<ul style="list-style-type: none"> • J. Tyree • Project team 	<ul style="list-style-type: none"> • TBD
BSF 201640	P	<ul style="list-style-type: none"> • Complete review of all schizophrenia NCEs with expert panel • Complete staffing of internal project team, but halt further expenditure beyond looking at hepatic tox. and QTc • Understand Novartis contract and level of interest 	<ul style="list-style-type: none"> • I. Loew-Freidrich • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
BSF 190555	P	<ul style="list-style-type: none"> • Complete review as above • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • I. Loew-Freidrich 	<ul style="list-style-type: none"> • As above
BSF 74398	C (no cost)	<ul style="list-style-type: none"> • Allow DevCo to continue development • Re-look at relationship with DevCo 	<ul style="list-style-type: none"> • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
Diluadid Oros	Hold/T	<ul style="list-style-type: none"> • Return to ALZA or out-license to other interested partner 	<ul style="list-style-type: none"> • J. Tyree 	<ul style="list-style-type: none"> • TBD
Hydrocodone	C	<ul style="list-style-type: none"> • Assess regulatory pathway • Understand DEA impact on manufacturing 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • By May
Bimoclomol (ABT 822)	P	<ul style="list-style-type: none"> • Await data from ongoing trial in April before deciding whether to continue - probable T • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • April

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Gastro-enterology Ganaton	P	<ul style="list-style-type: none"> • Conduct U.S. commercial assessment with TAP • Assess how to position in Europe versus generics and implications for comparative trial • Develop model to assess spend at different termination points 	• E. Fiorentino	• By June
	T	<ul style="list-style-type: none"> • Terminate outside Japan 	• Bob Funck	• By May
	C	<ul style="list-style-type: none"> • Develop and pursue a small PoC trial in humans ASAP (consider niche indication first and leverage Marlene's expertise) • Conduct market research on IBS versus constipation (including pricing) 	• Project team	• Immediate
Immunology D2E7			• Project team	• ASAP
			• E. Fiorentino	
	C	<ul style="list-style-type: none"> • Conduct intensive product review <ul style="list-style-type: none"> – 2 day meeting with J. Leonard's group (already in process) – ½ day session with senior management group • Important actions include <ul style="list-style-type: none"> – Approach FDA for fast track and compassionate use – Develop strategy for DMARD claim in first submission – Assess need for Enbrel assay to detect HAHA's – Assess delivery device options – Evaluate additional indications (e.g., psoriasis, Crohns, heart failure) and pediatric program – Profile Celltech product – Assess impact of additional IV program on reimbursement • Develop list of potential marketing partners for quids 	• J. Leonard	• By May
			• Various	• By May
			• J. Tyree	

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Immunology (continued) Segard	Hold	<ul style="list-style-type: none"> • Continue filing in EU and Canada • Put on hold in US – consider creating a small team in the US to analyse data, propose smaller PII study • Research pricing, marketing and Phase IV plans in Europe • Look at TNF-alpha levels retrospectively to see stratification with IL-6 • Assess manufacturing strategy • Identify potential out-licensing opportunities (Genentech) 	<ul style="list-style-type: none"> • Project team • J. Leonard 	<ul style="list-style-type: none"> • Ongoing
J695	P	<ul style="list-style-type: none"> • Decide on most attractive indications from Abbott and partner perspective • Discuss with partner ways to share the various indications and potential for TNF-alpha combinations • Add commercial person to the project team by this week 	<ul style="list-style-type: none"> • J. Tyree • E. Fiorentino • J. Tyree • Ongoing 	<ul style="list-style-type: none"> • ASAP

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
PIV programs Clarithromycin	C	• None identified	-	-
Omnicef	C	• None identified	-	-
Kaletra	C	• None identified	-	-
Norvir	C	• None identified	-	-
Meridia	Hold	<ul style="list-style-type: none"> • Conduct commercial assessment for CNS and depression (P&L) • Assess combination therapy with fibrates • Assess outcomes trial design to meet preferred commercial profile; determine payback 	<ul style="list-style-type: none"> • B. Dempsey, J. Arnott, E. Fiorentino • Project team 	<ul style="list-style-type: none"> • ASAP
Uprima	C	• Ensure no redundant trials with TAP in Europe	• Project team	• Ongoing
Trandolapril patch	T	• Halt all activities	• Project team	• Immediate
Trandolapril "Invest" clinical program	P	• Review trial in more detail (reduce complexity and risk)	• E. Fiorentino	• By May
Other trandolapril trials	C	• Continue "Create", "Peace" and "Benedict" trial programs	• Project team	• Ongoing
Fenofibrate	C	• Develop co-formulation ideas with Meridia and statins (including assessment of sales and costs)	• Project team	-
Depakote	C	• None identified	-	-
Gengraf	C	• None identified	-	-

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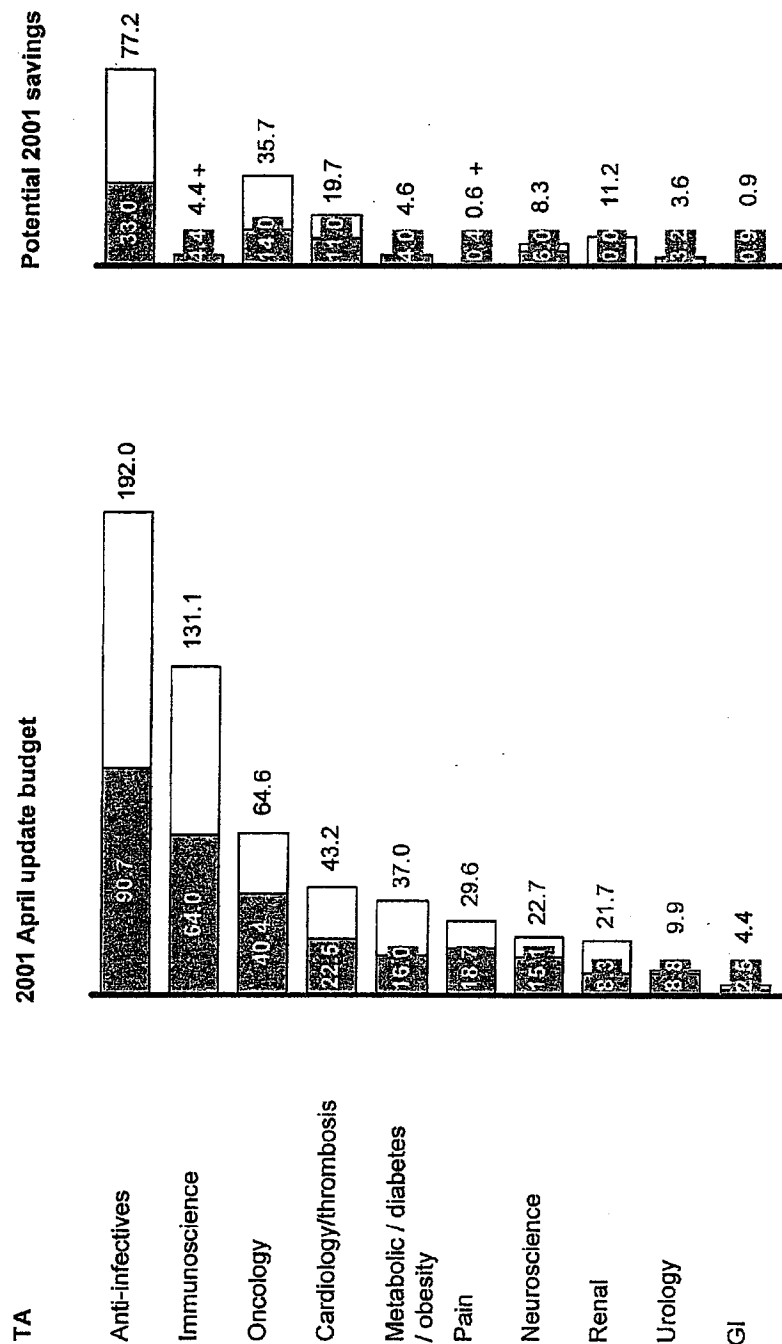
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POTENTIAL DEVELOPMENT PROGRAM SAVINGS IN 2001 IF TA TERMINATED

\$ Millions

External
Internal



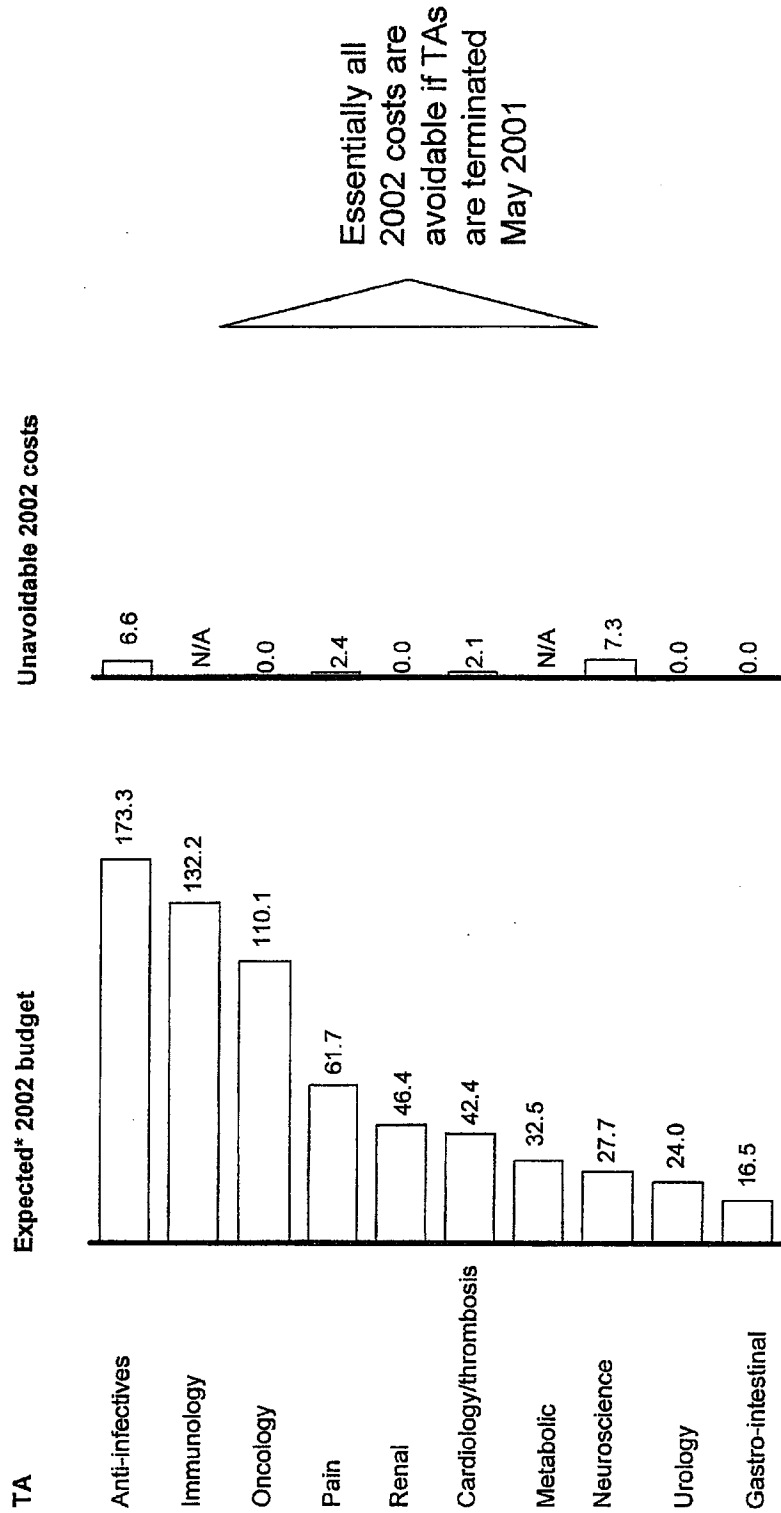
Note: Because of incomplete survey responses assumes limited savings from sibutramine, B201640, T4/T3, Synthroid, Vicoprofen, Dilaudid, Hydrocodone, PEG-Hirudin, and BSF 420627

Source: GPRD Finance

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POTENTIAL DEVELOPMENT PROGRAM SAVINGS IN 2002 IF TA TERMINATED

\$ Millions



* Risk adjusted

Note: N/A means not available

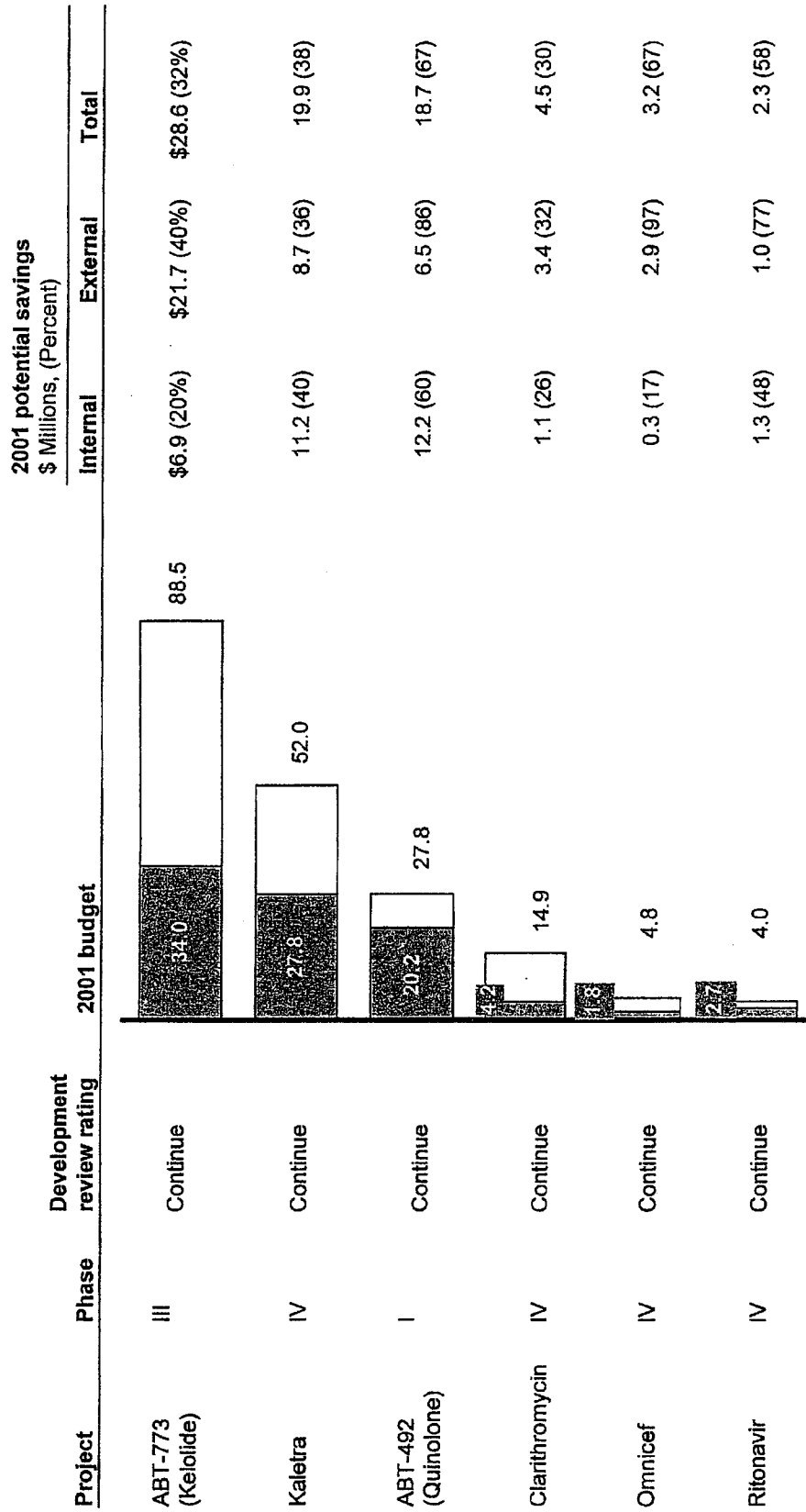
Source: GPRD Finance

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POTENTIAL SAVINGS – ANTI-INFECTIVES

\$ Millions

□ External
 ■ Internal



Source: GPRD Finance

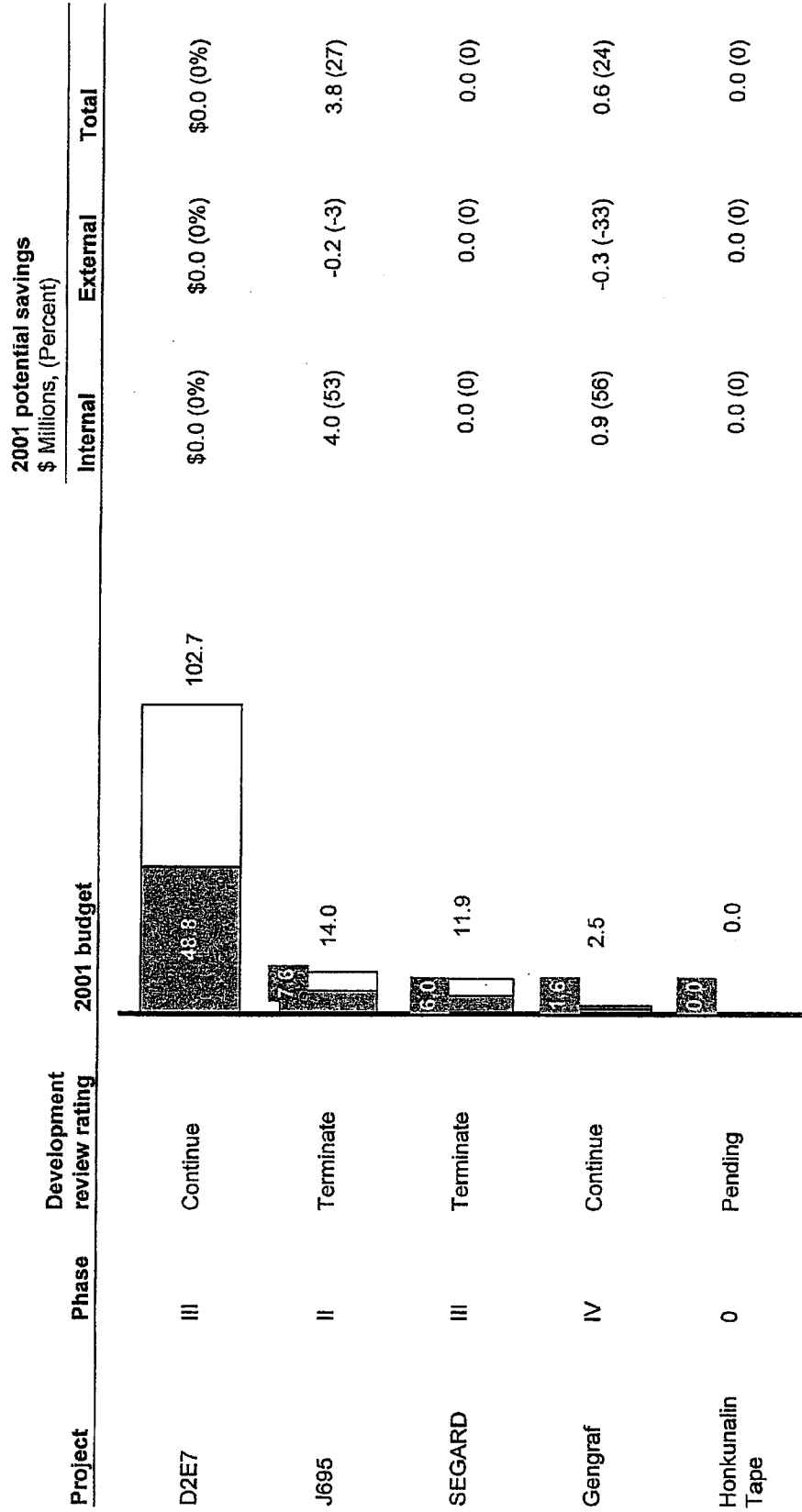
17

CH-CH-228013-013j/aaRD

POTENTIAL SAVINGS – IMMUNOLOGY

\$ Millions

□ External
 ■ Internal



Source: GPRD Finance

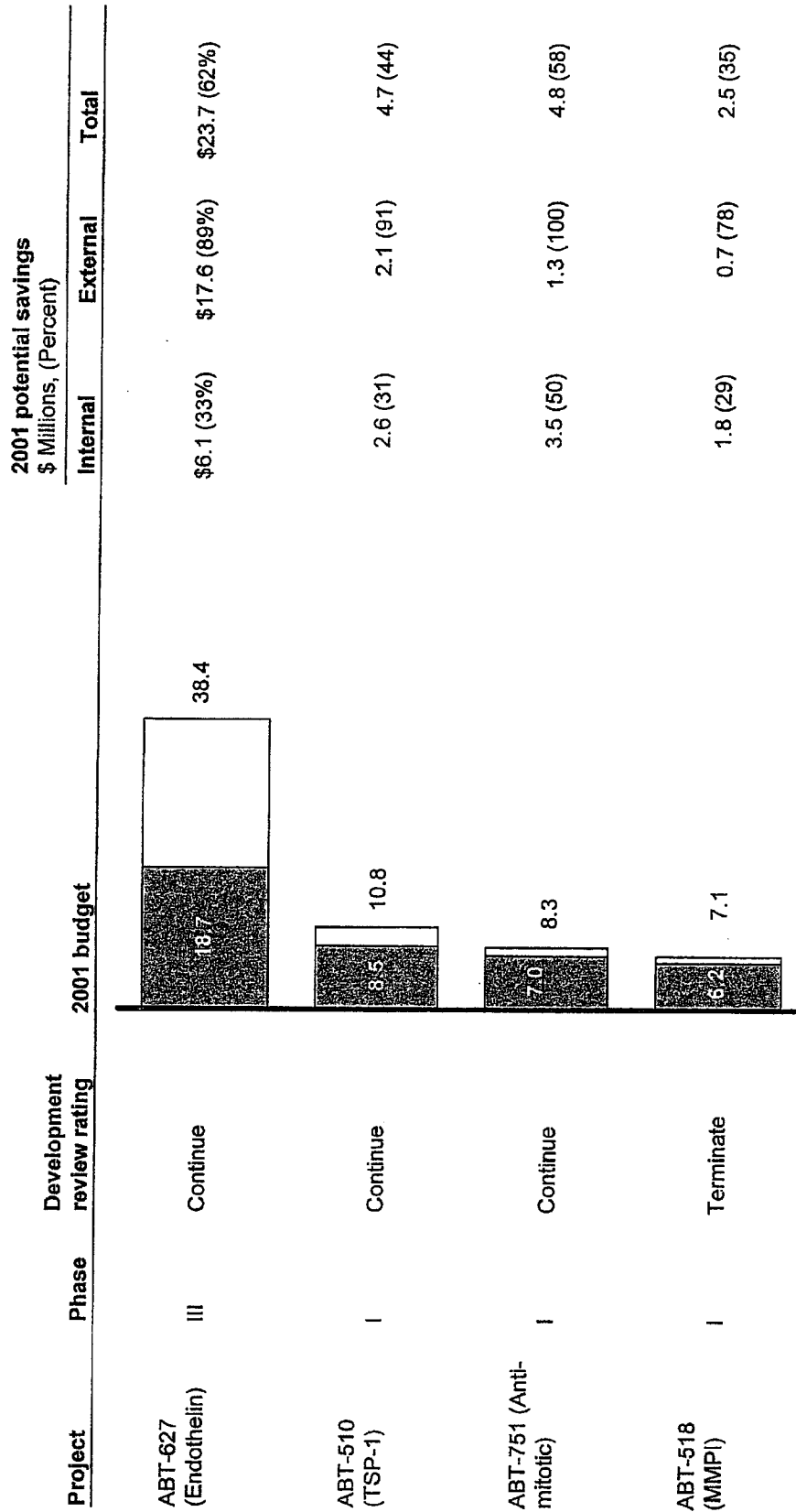
18

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POTENTIAL SAVINGS – ONCOLOGY

\$ Millions

External
Internal



Source: GPRD Finance

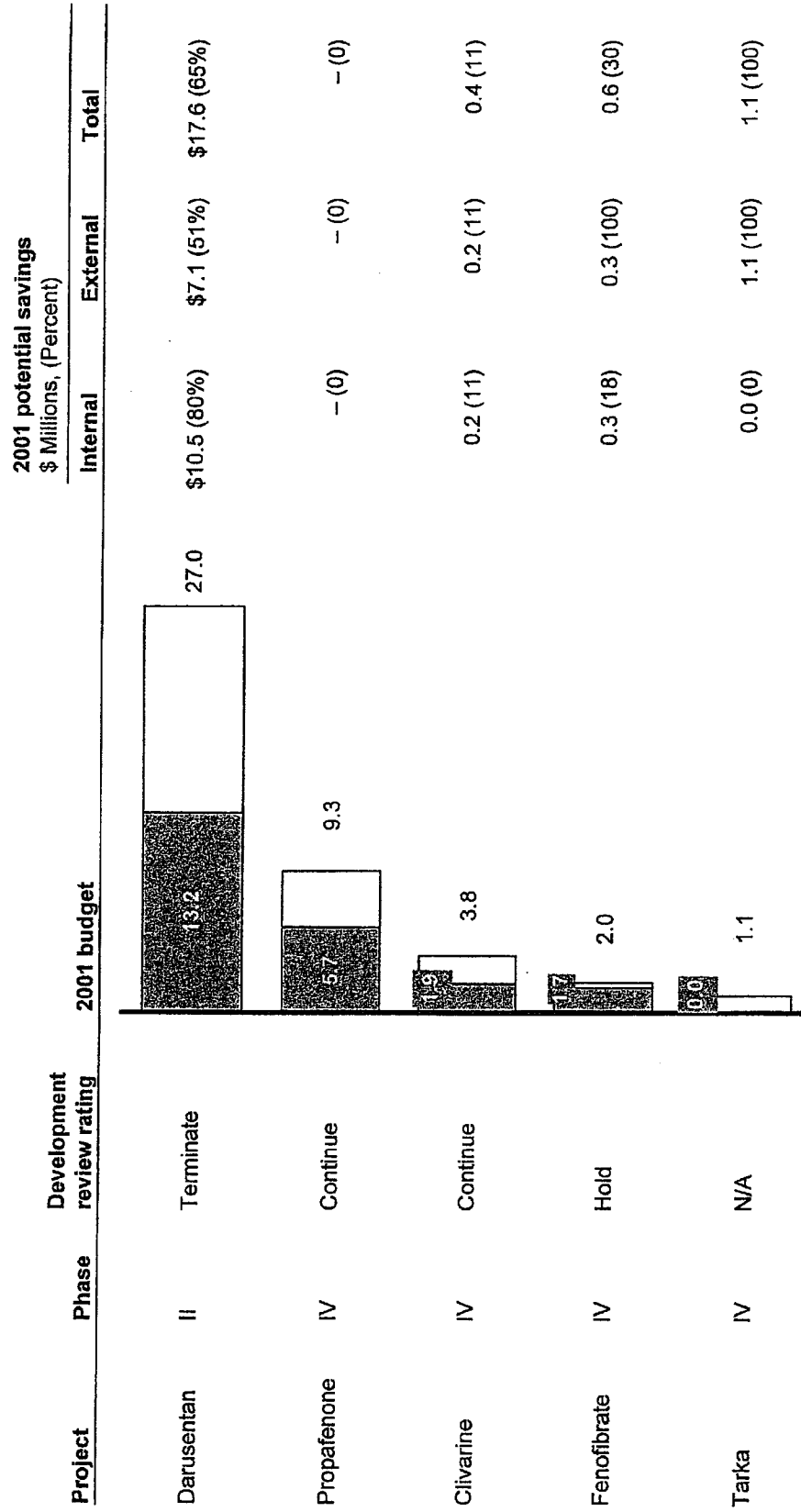
19

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POTENTIAL SAVINGS – CARDIOLOGY/THROMBOSIS

\$ Millions

□ External
 ■ Internal



Source: GPRD Finance

20

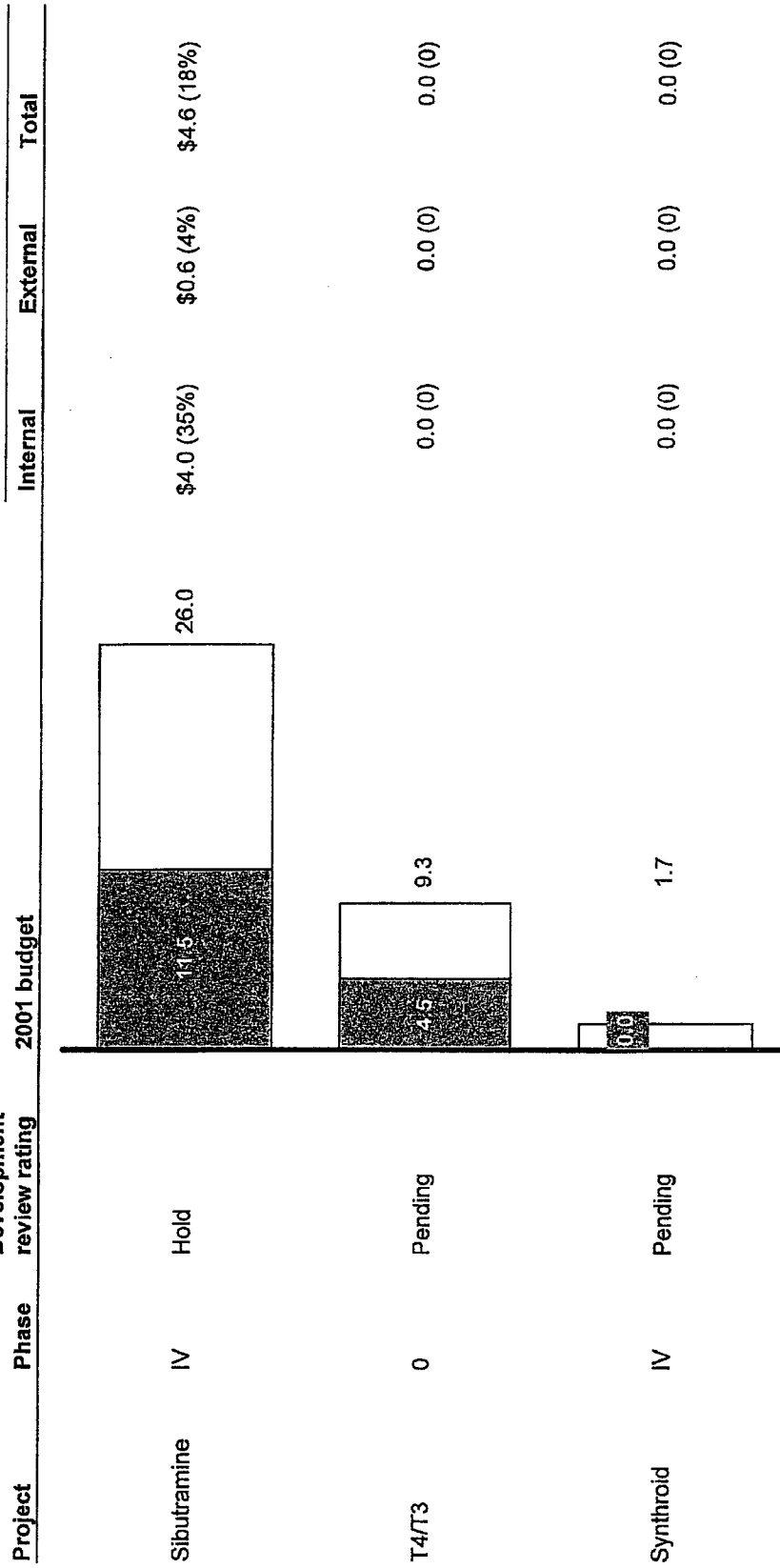
CH-CH-228013-013/b/aarD

POTENTIAL SAVINGS – METABOLIC / DIABETES / OBESITY

\$ Millions

External
Internal

2001 potential savings
\$ Millions, (Percent)



Source: GPRD Finance

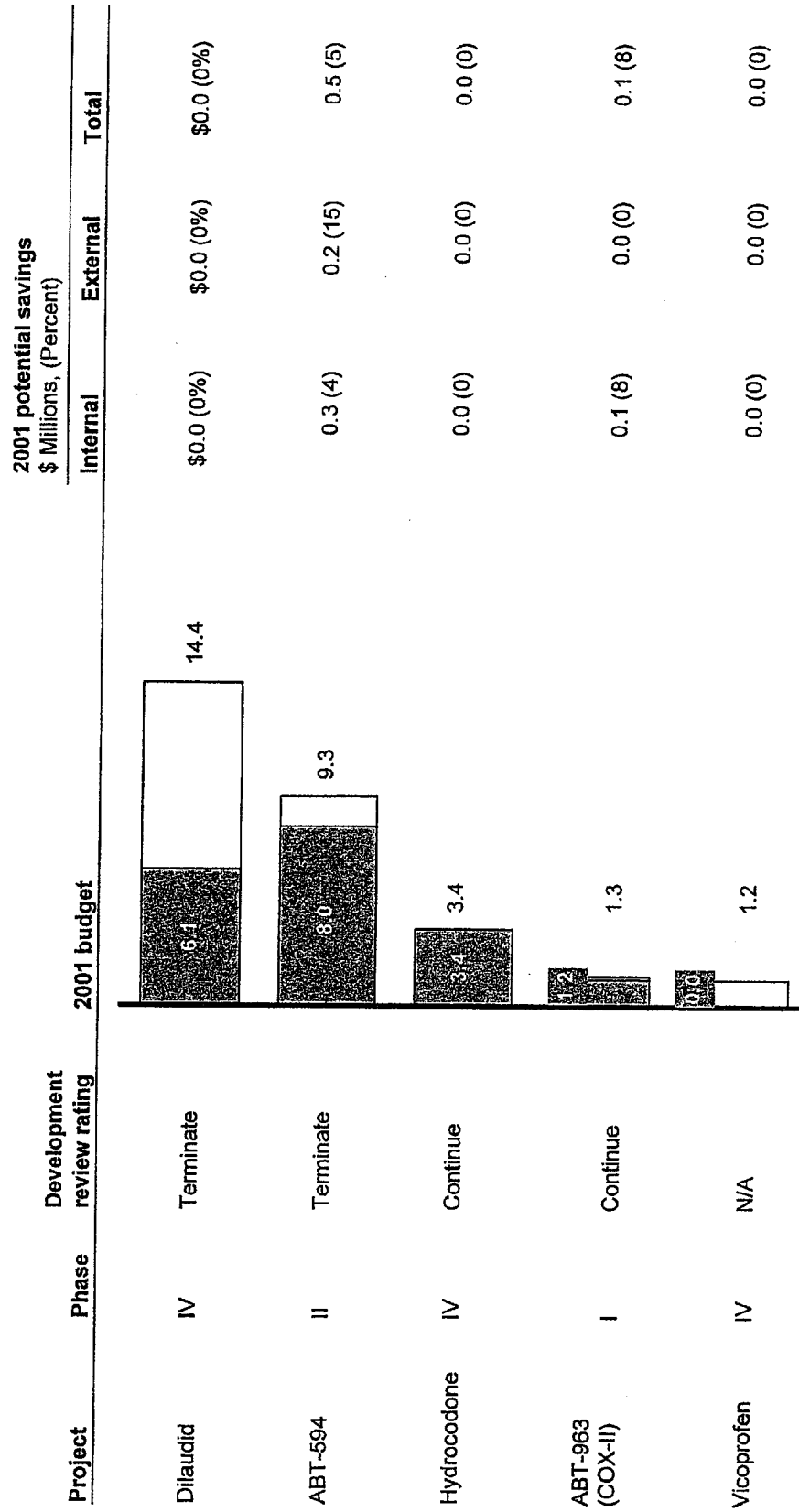
21

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POTENTIAL SAVINGS – PAIN

\$ Millions

External
Internal



Source: GPRD Finance

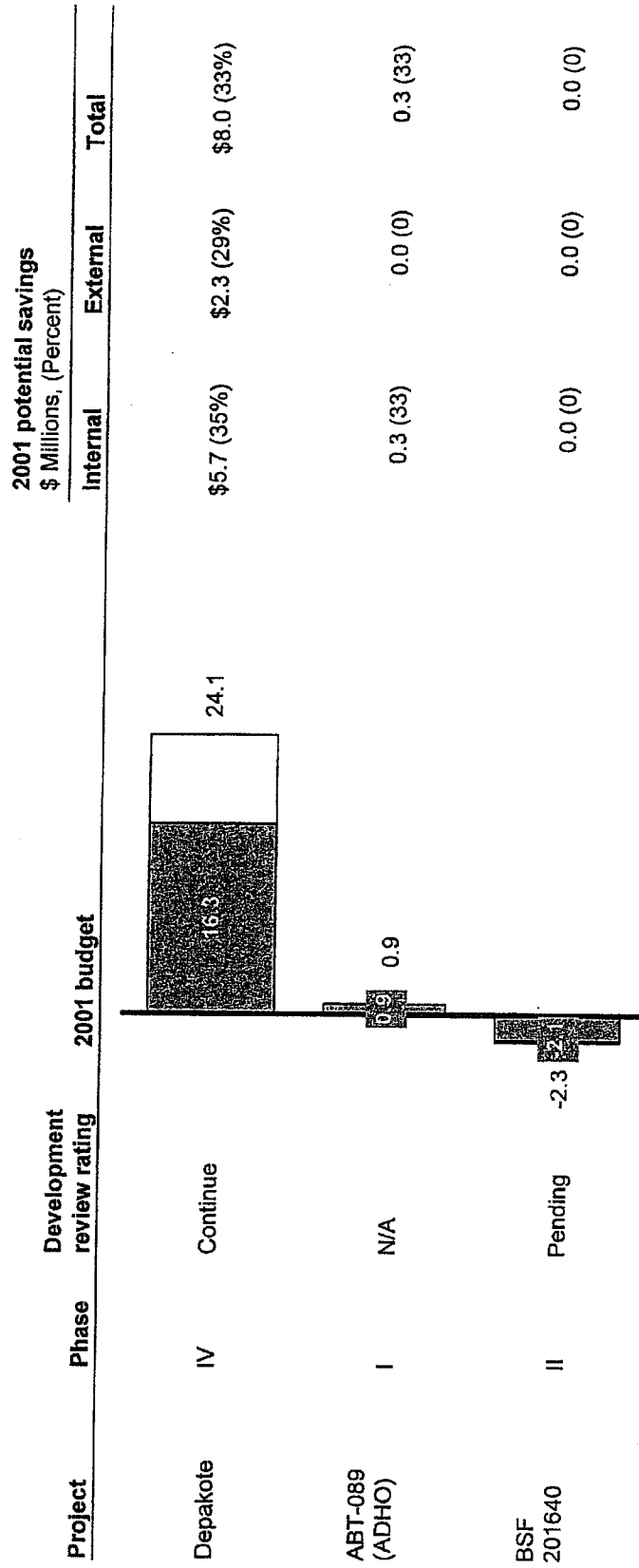
22

CH-CH-228013-013jb/aaRD

POTENTIAL SAVINGS – NEUROSCIENCE

\$ Millions

□ External
 ■ Internal



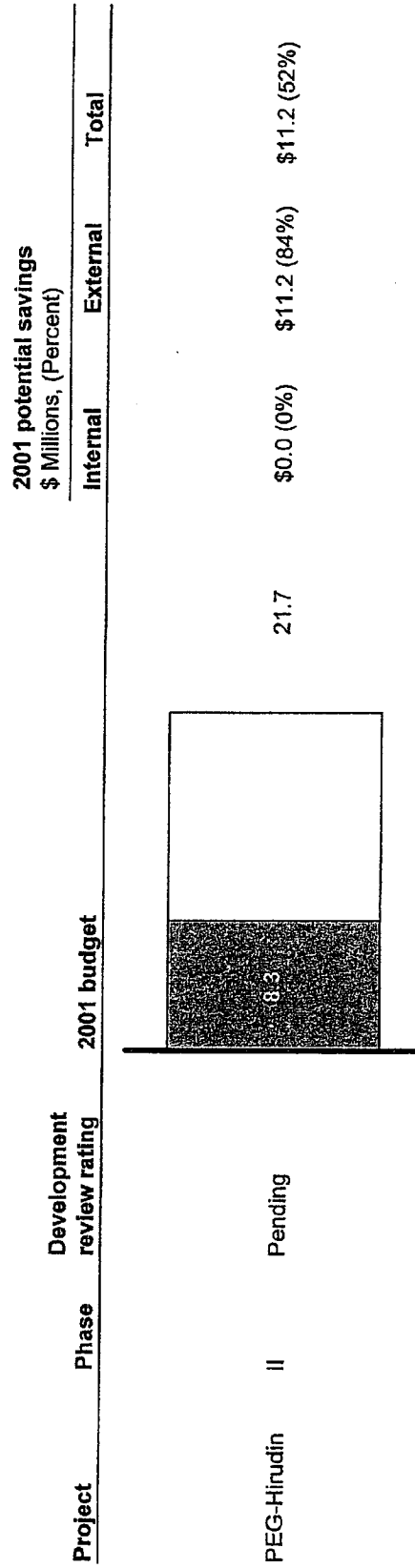
Source: GPRD Finance

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POTENTIAL SAVINGS – RENAL \$ Millions

☐ External
☒ Internal



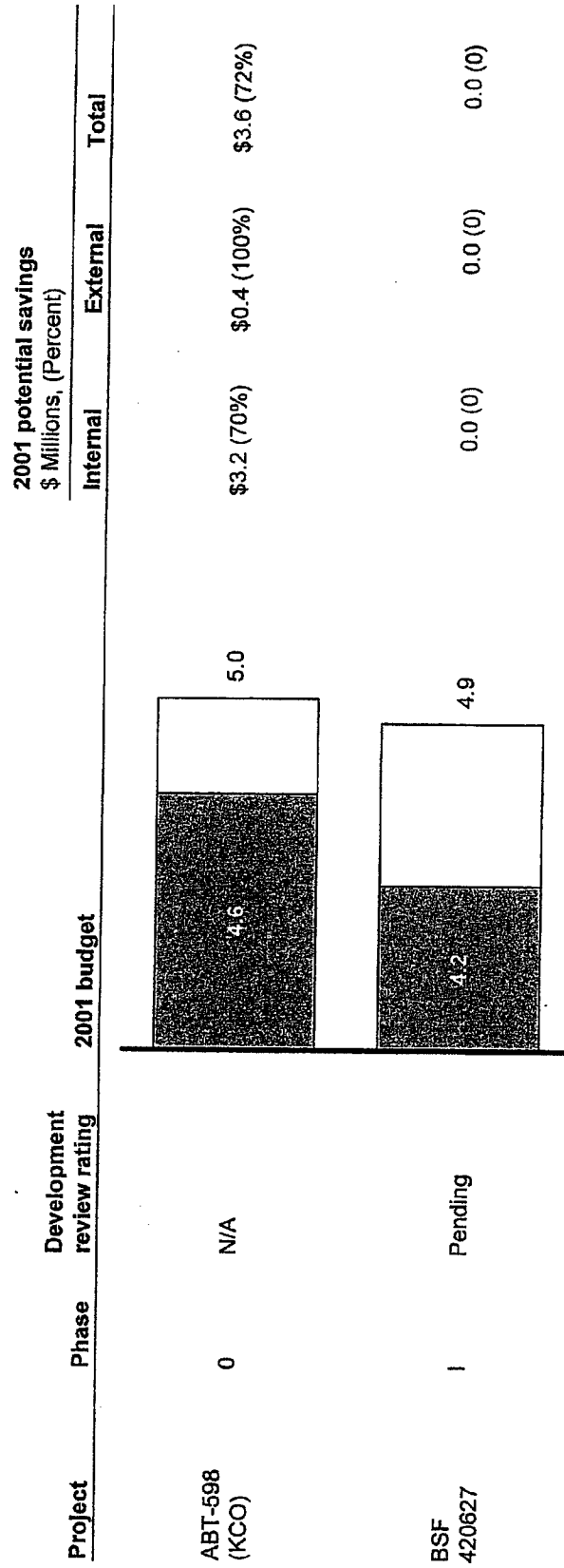
Source: GPRD Finance

CH-CH-228013-013jb/aaRD

POTENTIAL SAVINGS – UROLOGY

\$ Millions

External
Internal



Source: GPRD Finance

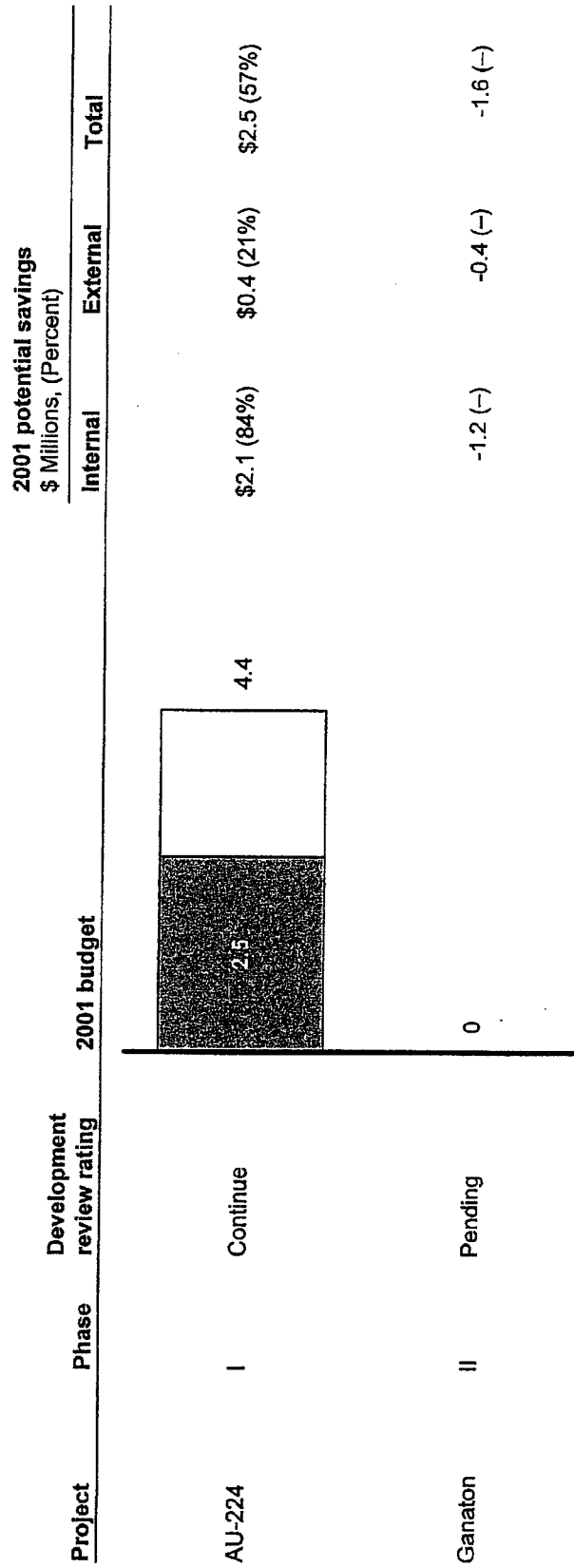
25

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POTENTIAL SAVINGS – GI

\$ Millions

External
Internal



Source: GPRD Finance

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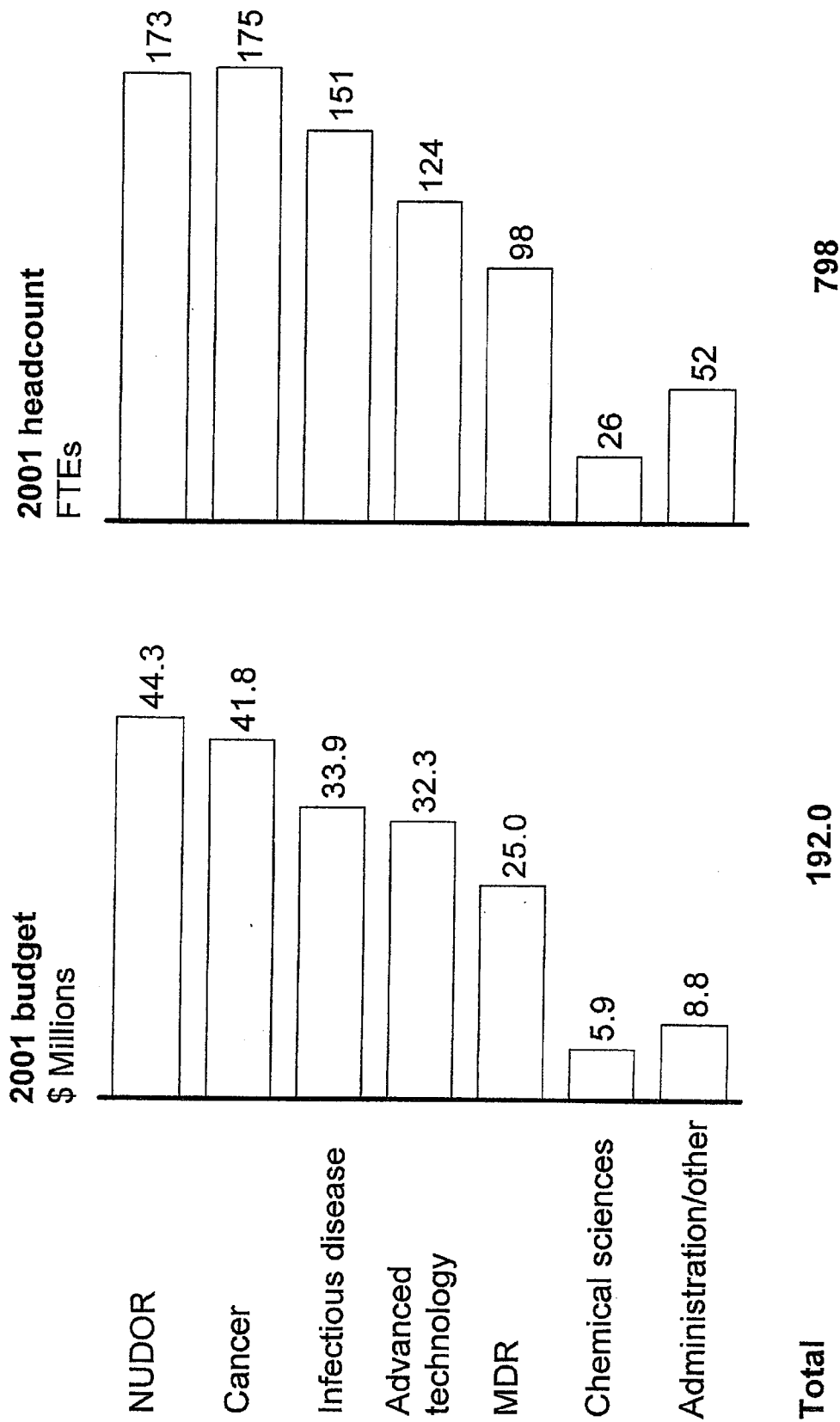
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APRIL UPDATE

ABBOTT PARK DISCOVERY – OVERVIEW \$ Millions; FTE

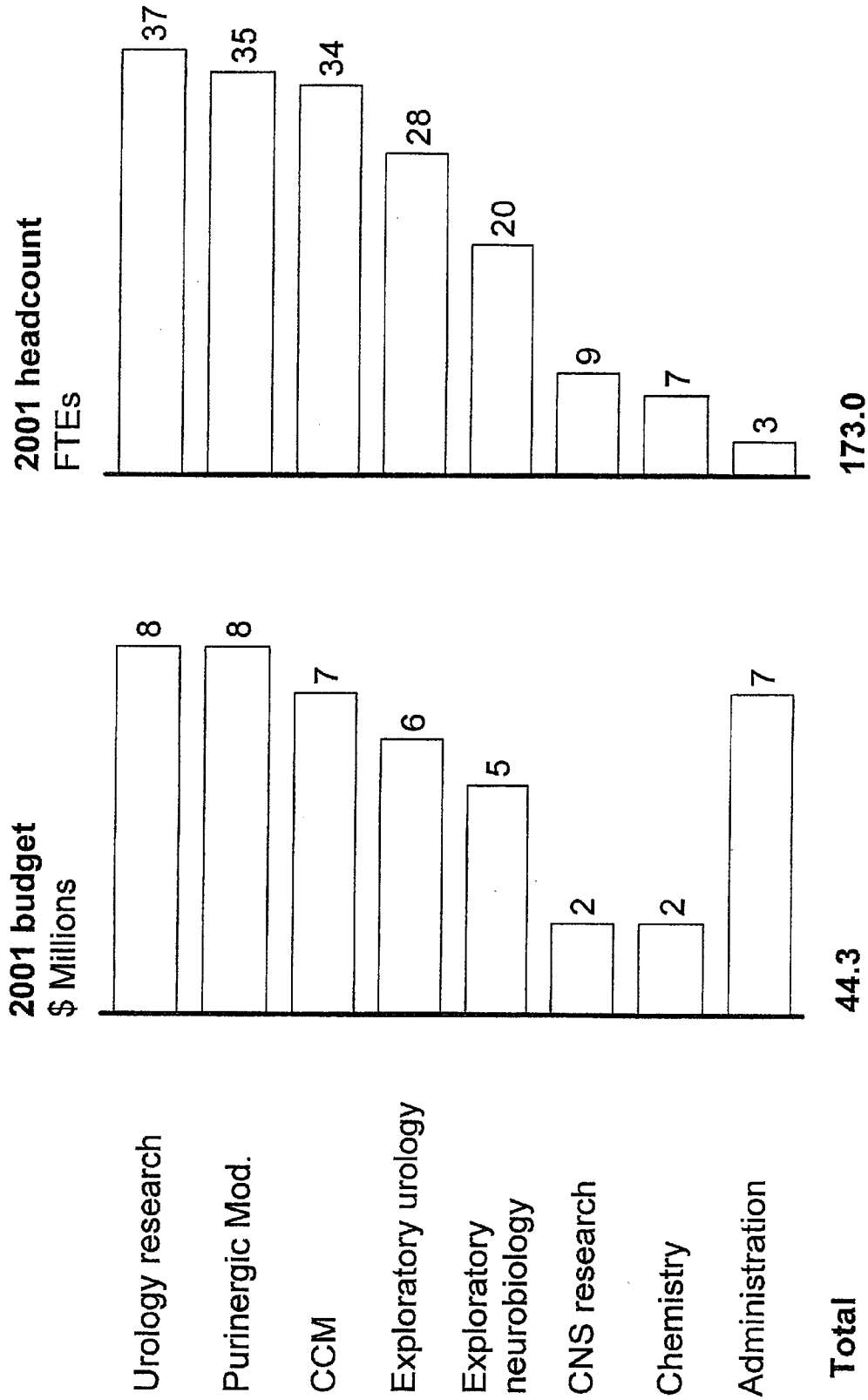


Source: GPRD Finance

CH-CH-228013-013[b]/aaRD

PRELIMINARY**ABBOTT PARK DISCOVERY – NUDOR**

\$ Millions; FTE



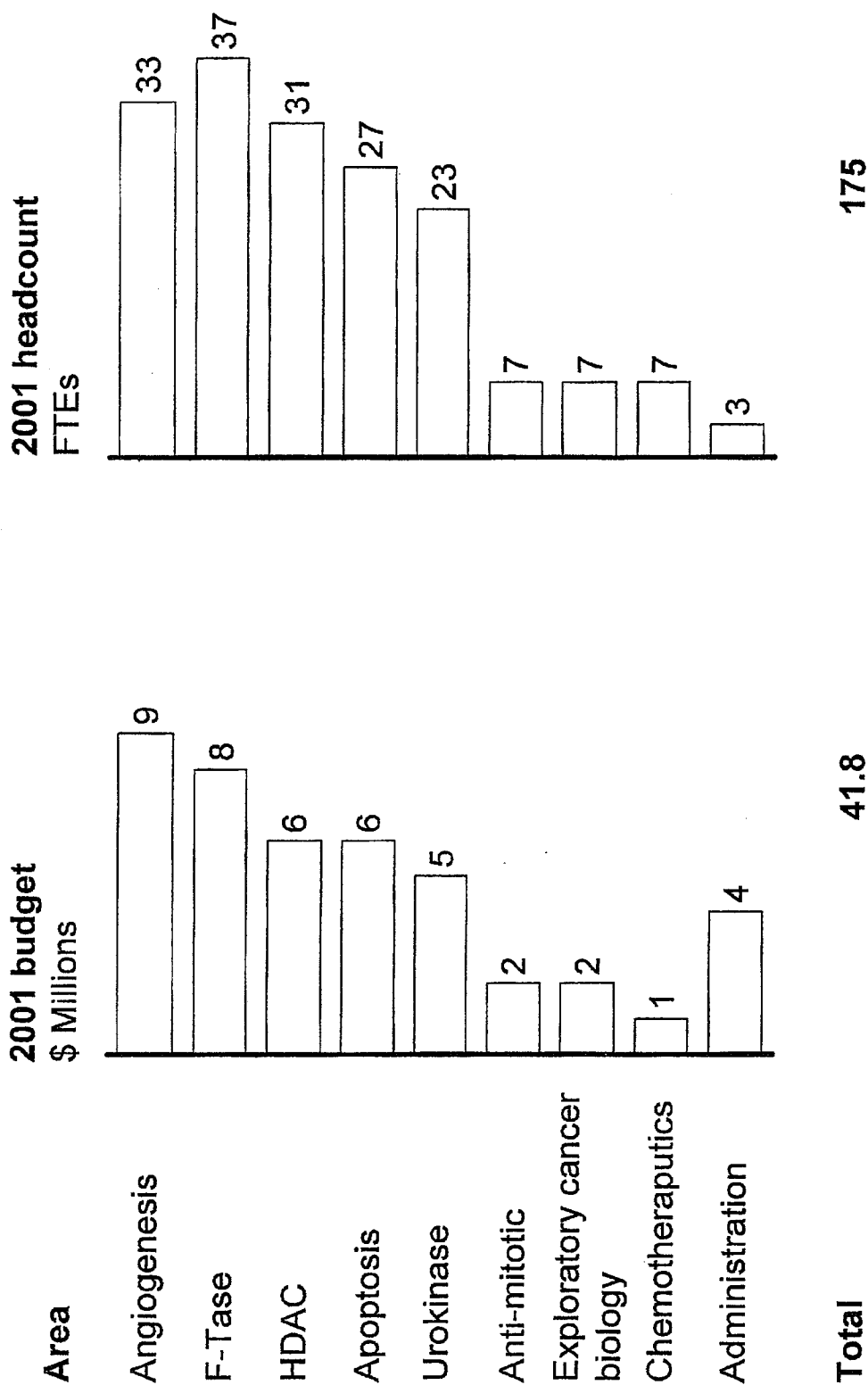
Source: GPRD Finance

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APRIL UPDATE**ABBOTT PARK DISCOVERY – CANCER**

\$ Millions; FTE



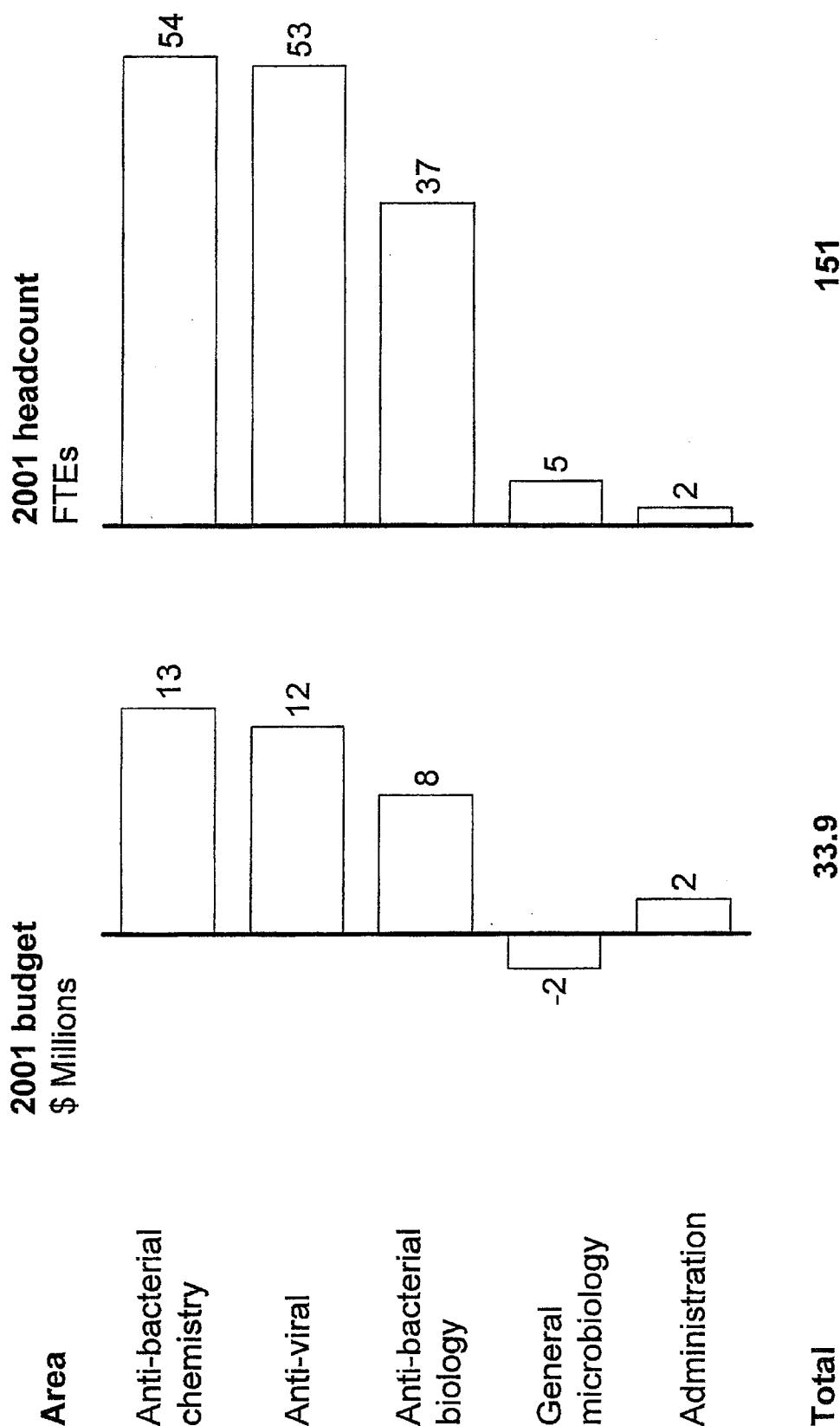
Source: GPRD Finance

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ABBOTT PARK DISCOVERY – INFECTIOUS DISEASE

\$ Millions; FTE

APRIL UPDATE

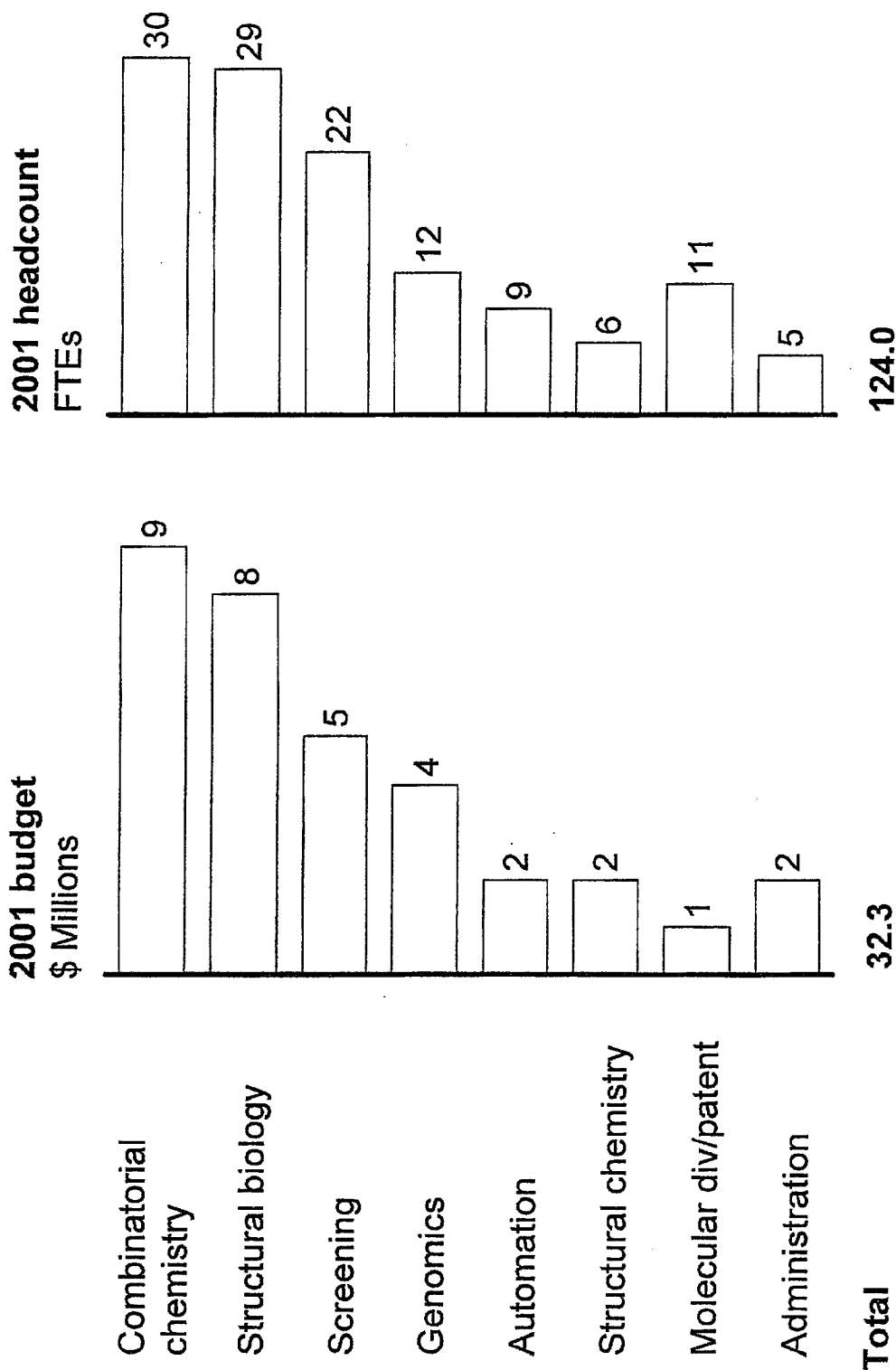
Source: GPRD Finance

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PRELIMINARY**ABBOTT PARK DISCOVERY – ADVANCED TECHNOLOGY**

\$ Millions; FTE



Source: GPRD Finance

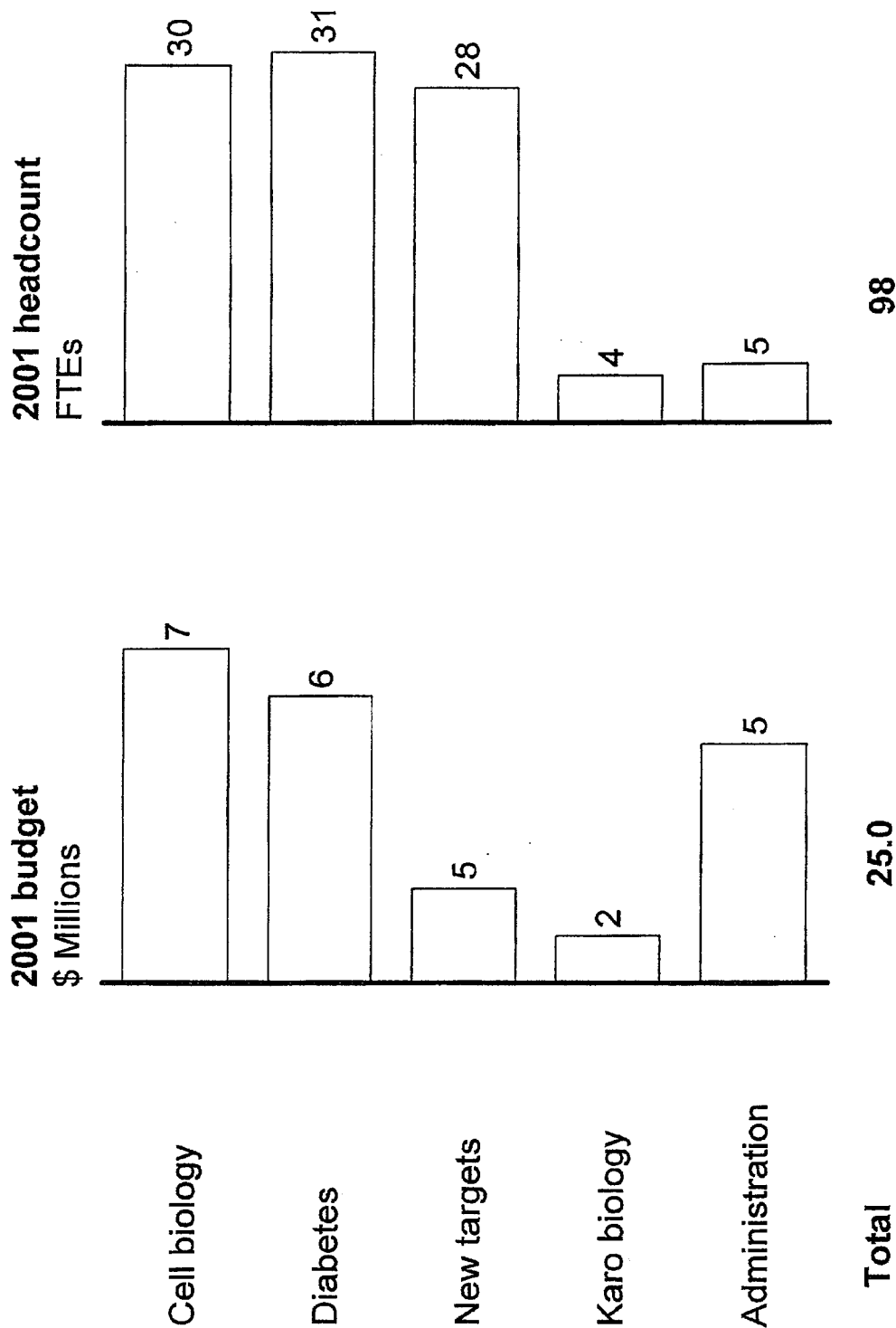
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PRELIMINARY

ABBOTT PARK DISCOVERY – MDR

\$ Millions; FTE



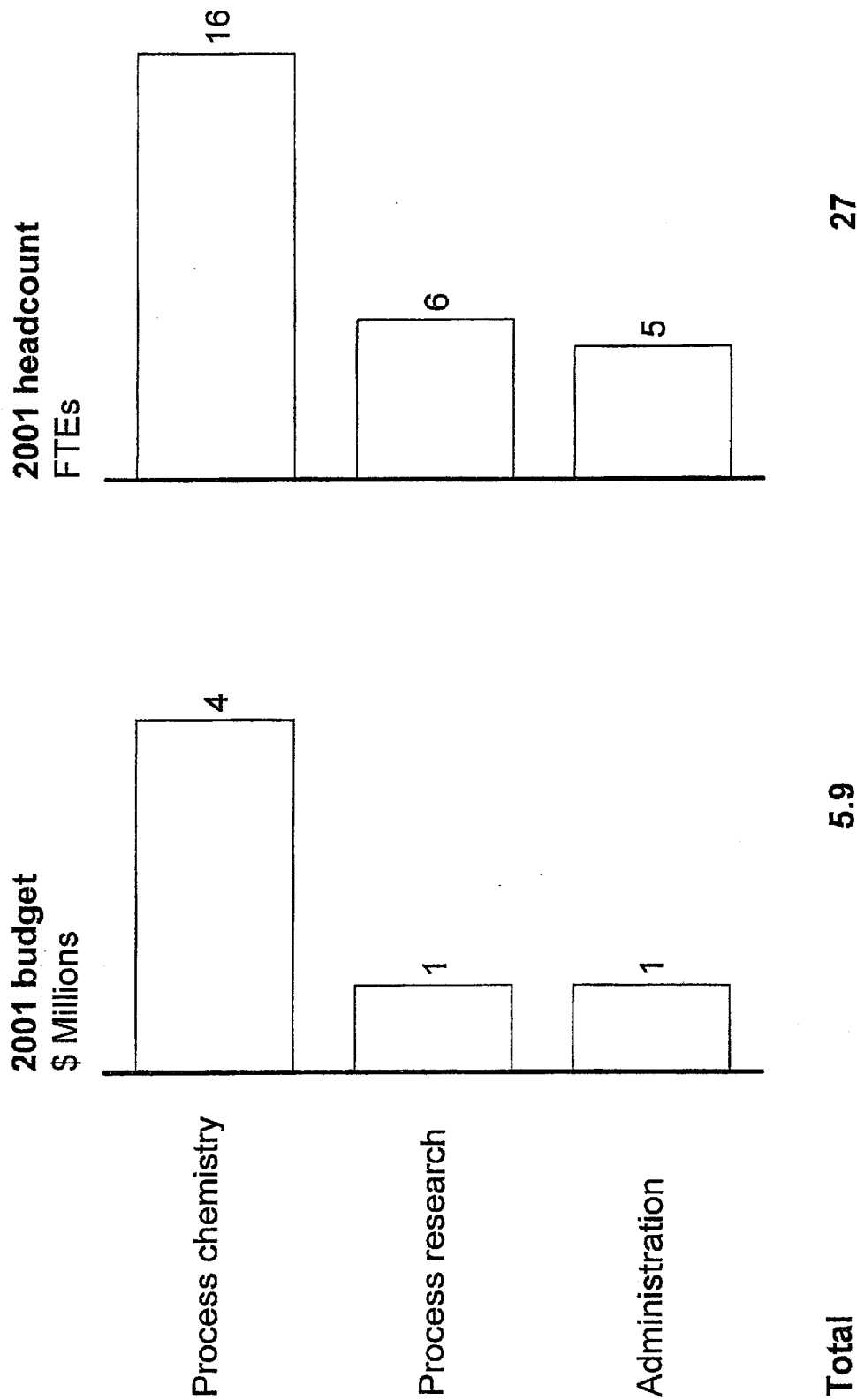
Source: GPRD Finance

CH-CH-228013-013j/aaRD

ABBOTT PARK DISCOVERY – CHEMICAL SCIENCES

\$ Millions; FTE

PRELIMINARY



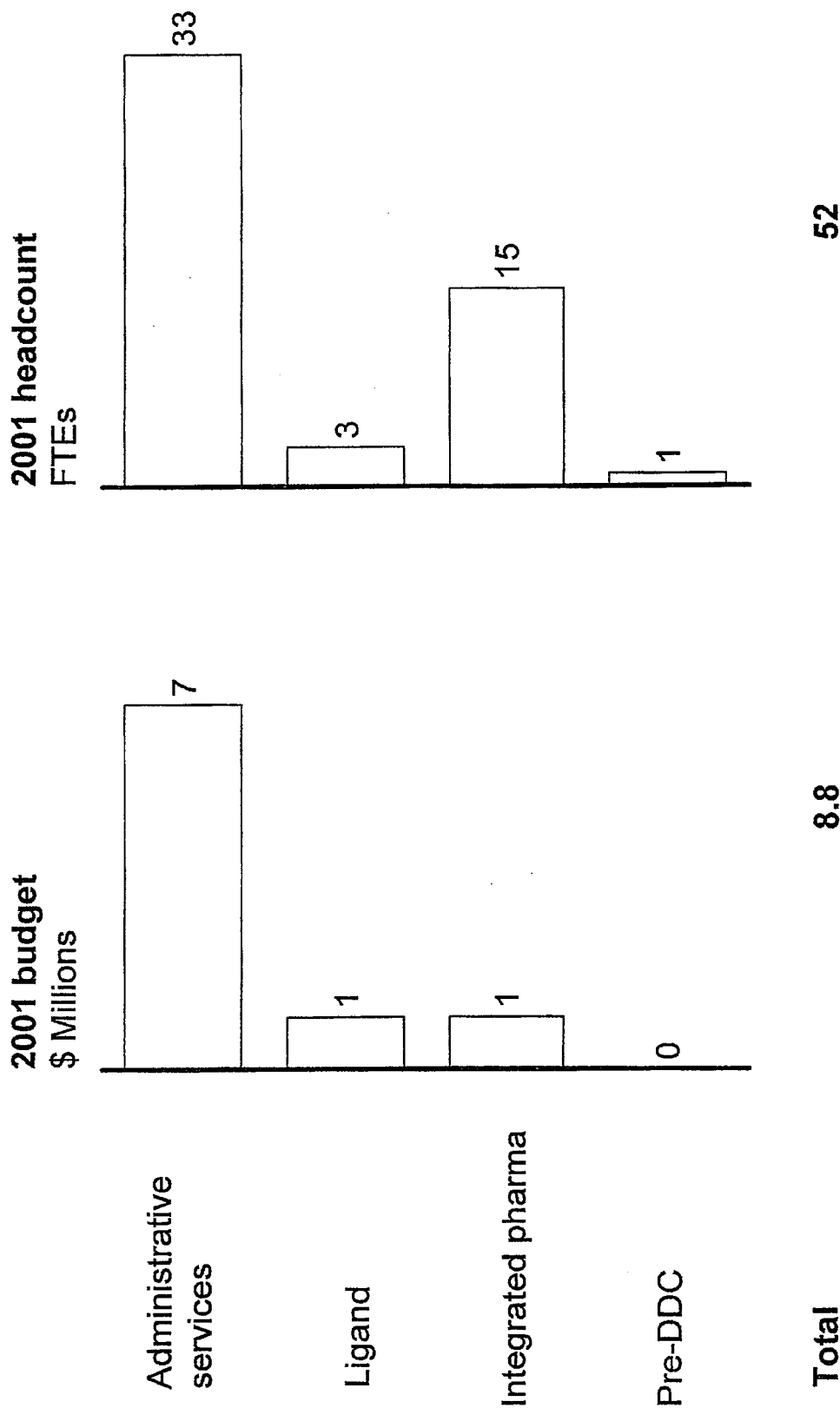
Source: GPRD Finance

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ABBOTT PARK DISCOVERY – ADMINISTRATION/OTHER

\$ Millions; FTE

PRELIMINARY

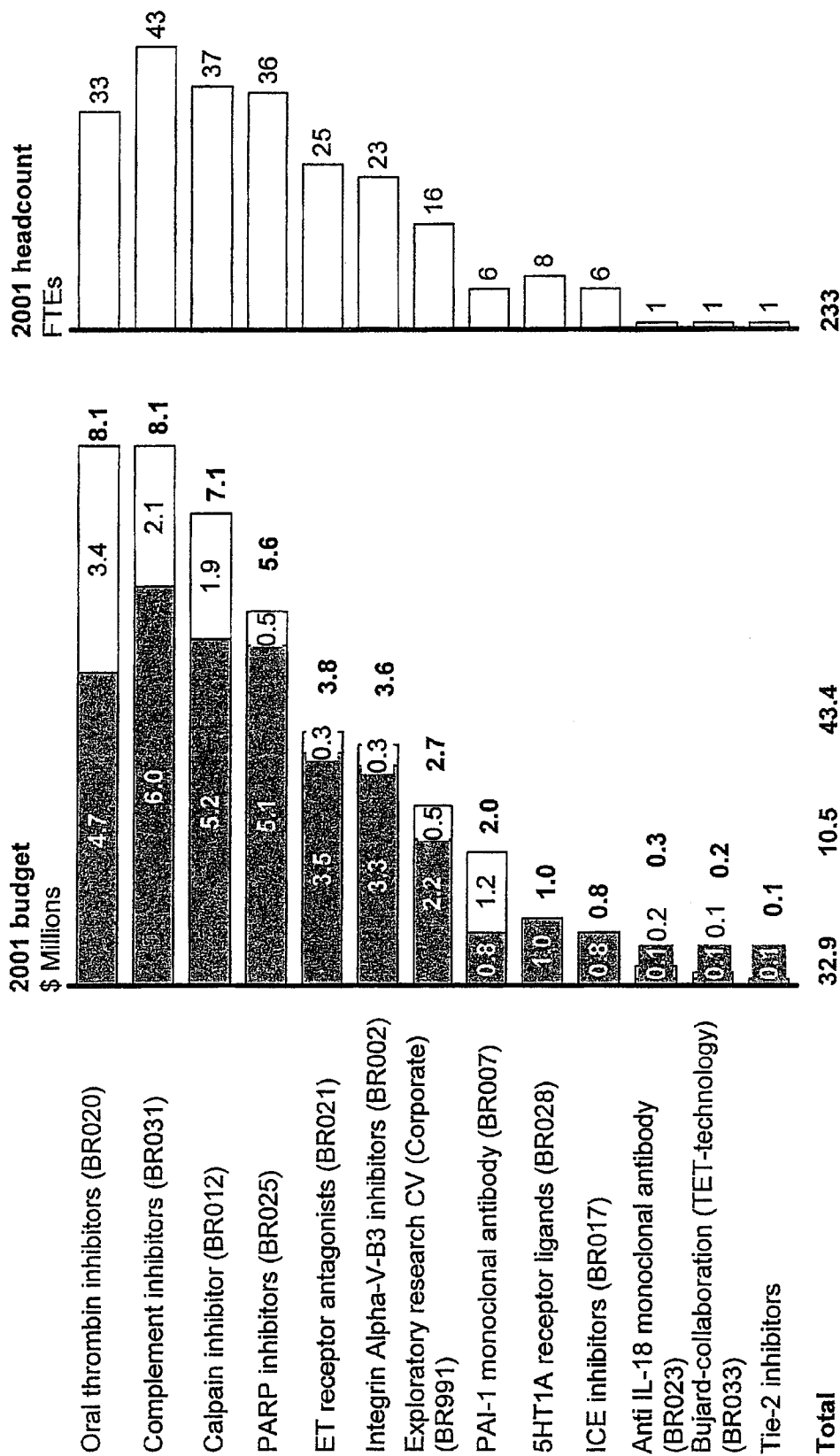
Source: GPRD Finance

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LUDWIGSHAFEN DISCOVERY**APRIL UPDATE**

Internal
External



Source: GPRD finance

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CH-CH-228013-013[b]/aaRD

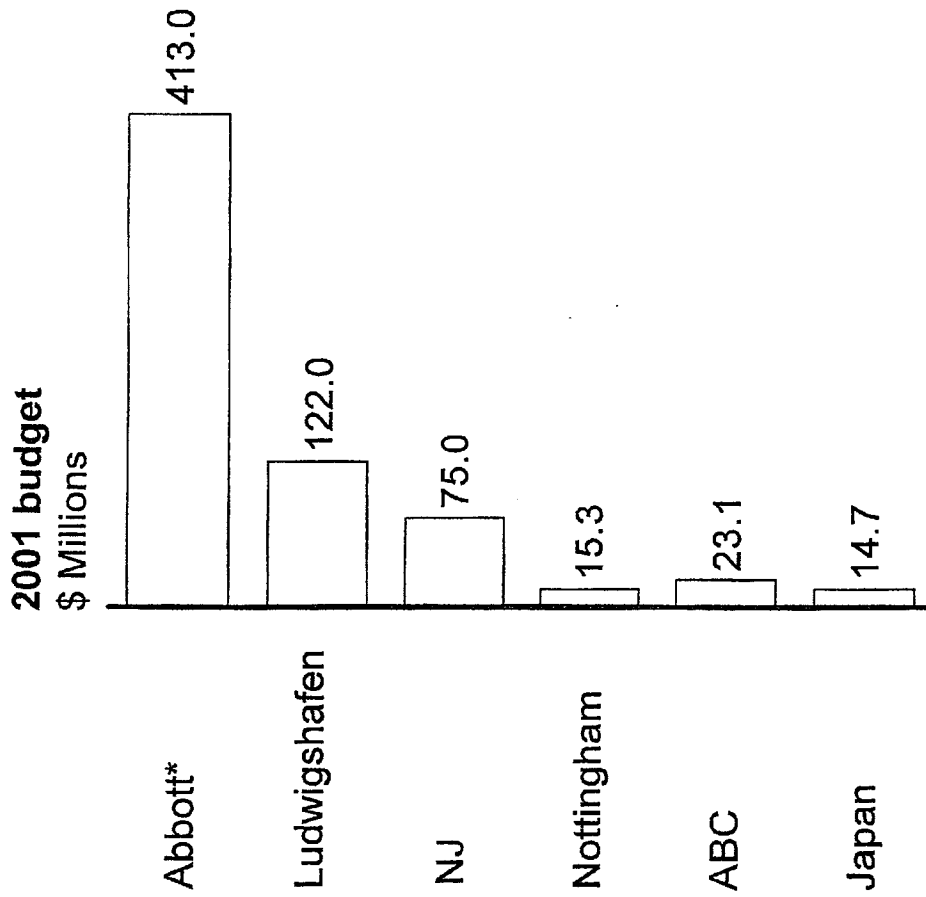
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APPROXIMATE

SUMMARY OF DEVELOPMENT RESOURCE ALLOCATION BY SITE

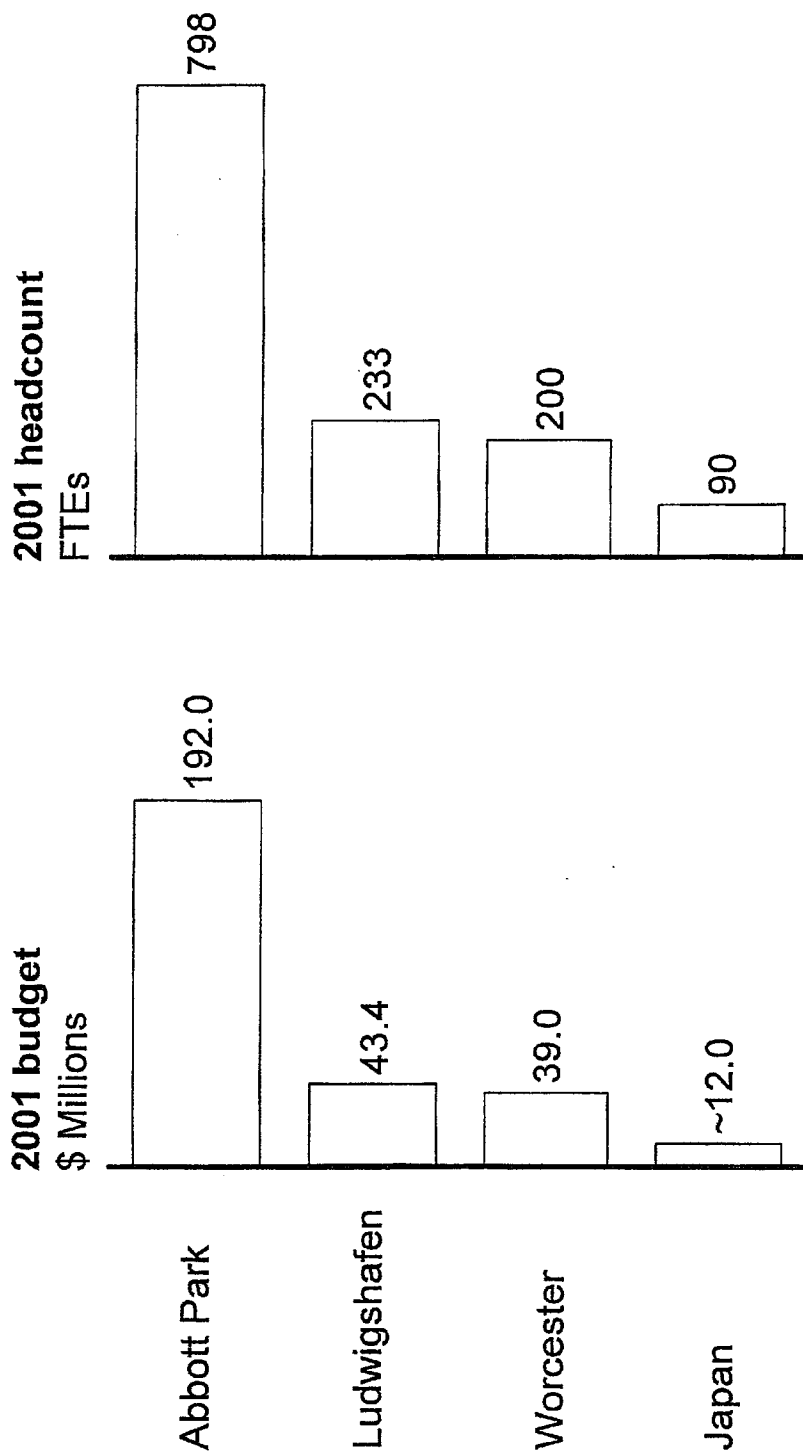


* Mostly Lake County; includes worldwide clinical trials
Source: GPRD Finance; Ludwigshafen Finance

CH-CH-228013-013j/aaRD

PRELIMINARY

SUMMARY OF DISCOVERY RESOURCE ALLOCATION BY SITE



Source: GPRD Finance

CH-CH-228013-013jb/aaRD

CONTENTS

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CH-CH-228013-013jb/aaRD

DEVELOPMENT PROJECT DECISION TEMPLATE – ANTI-INFECTIVES

Project	Continue	Terminate	Next steps	Responsibility
ABT-773 (ketolide)				
Kaletra				
ABT-492 (quinolone)				
Clarithromycin				
Omnicef				
Ritonavir				

CH-CH-228013-013jb/aaRD

DEVELOPMENT PROJECT DECISION TEMPLATE – IMMUNOSCIENCE

Project	Continue	Terminate	Next steps	Responsibility
D2E7				
J695				
Segard				
Gengraf				
Honkunalin tape				

CH-CH-228013-013jb/aaRD

DEVELOPMENT PROJECT DECISION TEMPLATE – ONCOLOGY

Project	Continue	Terminate	Next steps	Responsibility
ABT-627 (endothelin)				
ABT-510 (TSP-1)				
ABT-751 (anti-mitotic)				
ABT-518 (MMPI)				

CH-CH-228013-013jb/aaRD

DEVELOPMENT PROJECT DECISION TEMPLATE – CARDIOLOGY/THROMBOSIS

Project	Continue	Terminate	Next steps	Responsibility
Darusentan				
Propafenone				
Clivarine				
Fenofibrate				
Tarka				

CH-CH-228013-013jb/aarD

**DEVELOPMENT PROJECT DECISION TEMPLATE –
METABOLIC/DIABETES/OBESITY**

Project	Continue	Terminate	Next steps	Responsibility
Sibutramine				
T4/T3				
Synthroid				

CH-CH-228013-013jb/aard

DEVELOPMENT PROJECT DECISION TEMPLATE – PAIN

Project	Continue	Terminate	Next steps	Responsibility
Dilaudid				
ABT-594				
Hydrocodone				
ABT-963 (cox II)				
Vicoprofen				

CH-CH-228013-013jb/aaRD

DEVELOPMENT PROJECT DECISION TEMPLATE – NEUROSCIENCE

Project	Continue	Terminate	Next steps	Responsibility
Depakote				
BSF 201640				
ABT-089 (ADHD)				

CH-CH-228013-013jb/aaRD

DEVELOPMENT PROJECT DECISION TEMPLATE – RENAL

Project	Continue	Terminate	Next steps	Responsibility
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PEG-Hirudin

CH-CH-228013-013jb/aaRD

DEVELOPMENT PROJECT DECISION TEMPLATE – UROLOGY

Project	Continue	Terminate	Next steps	Responsibility
ABT-598 (KCO)				
BSF 420627				

CH-CH-228013-013jb/aaRD

DEVELOPMENT PROJECT DECISION TEMPLATE – GI

Project	Continue	Terminate	Next steps	Responsibility
AU 224				
Ganaton				

CH-CH-228013-013jb/aaRD

DISCOVERY PROJECT DECISION TEMPLATE – NUDOR

Project	Continue	Terminate	Next steps	Responsibility
Urology research				
Purinergic mod.				
CCM				
Exploratory urology				
Exploratory neurobiology				
CNS research				
Chemistry				

CH-CH-228013-013jb/aaRD

DISCOVERY PROJECT DECISION TEMPLATE – CANCER

Project	Continue	Terminate	Next steps	Responsibility
Angiogenesis				
F-Tase				
HDAC				
Apoptosis				
Exploratory cancer				
Urokinase				
Anti-mitotic				
Biology				
Chemotherapeutics				

CH-CH-228013-013jb/aaRD

DISCOVERY PROJECT DECISION TEMPLATE – INFECTIOUS DISEASE

Project	Continue	Terminate	Next steps	Responsibility
Anti-bacterial chemistry				
Anti-viral				
Anti-bacterial biology				
General microbiology				

CH-CH-228013-013jb/aaRD

**DISCOVERY PROJECT DECISION TEMPLATE –
ADVANCED TECHNOLOGY**

Project	Continue	Terminate	Next steps	Responsibility
Combinatorial chemistry				
Structural biology				
Screening				
Genomics				
Automation				
Structural chemistry				
Molecular div/ patent				

CH-CH-228013-013jb/aarD

DISCOVERY PROJECT DECISION TEMPLATE – MDR

Project	Continue	Terminate	Next steps	Responsibility
Cell biology				
Diabetes				
New targets				
Karo biology				

CH-CH-228013-013jb/aaRD

DISCOVERY PROJECT DECISION TEMPLATE – CHEMICAL SCIENCES

Project	Continue	Terminate	Next steps	Responsibility
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Process
chemistry

Process research

CH-CH-228013-013jb/aaRD

DISCOVERY PROJECT DECISION TEMPLATE – ADMINISTRATION/OTHER

Project	Continue	Terminate	Next steps	Responsibility
Ligand				
Integrated pharma				
Pre-DDC				

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SYNERGIES WITH ABBOTT'S OTHER BUSINESSES

Therapeutic area	Synergies
Anesthesia	<ul style="list-style-type: none"> • Hospital presence in OR and ICU creates opportunities for launching/ optimizing acute care cardiovascular products and for pain products • Infusion devices
Anti-infectives	<ul style="list-style-type: none"> • Genotype/phenotype monitoring with ADD
Cardiology/ thrombosis	<ul style="list-style-type: none"> • Potential opportunities in drug/device combinations (e.g., drug-coated stents, thrombolysis-related devices, etc.)
Immunosciences	<ul style="list-style-type: none"> • HPD Breonics (organ preservation for transplant) • Pain franchise – OA and RA • Discovery synergy with oncology • Nutritional (e.g., CD, renal dysfunction in transplant)
Metabolic/diabetes/ obesity	<ul style="list-style-type: none"> • Joint product offerings with Ross (Glucerna, Ensure) and MediSense (Precision QID, SofTac) • Co-develop new products with Ross, MediSense, ADD, and Pharmacogenetics • Bringing Tricor into franchise
Neuroscience	<ul style="list-style-type: none"> • Multiple synergies with other franchises <ul style="list-style-type: none"> – ADD: development of a diagnostic for Alzheimer's disease – Oncology: an additional channel for sales of anti-depressants – Diabetes: Potential use of H3 in obesity – Pain: synergies in molecular targets and neural systems beginning at the discovery level – Immunoscience: potential for Ab-based therapies and involvement of inflammatory mediators in neuropsychiatric diseases

Source: Strategy retreat template

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SYNERGIES WITH ABBOTT'S OTHER BUSINESSES (CONTINUED)

Therapeutic area	Synergies
Oncology	<ul style="list-style-type: none"> • Diagnostic and therapeutic antibodies • Tumor load testing • Pharmacodynamics and pharmacogenomics • Target therapy to tumor genotype
Pain	<ul style="list-style-type: none"> • Pain is associated with multiple other therapeutic areas (e.g., cancer, diabetes, neuroscience, and urology) • Discovery synergies with urology and neuroscience • Overlap with perioperative/anesthesia, acute care injectables, and animal health
Renal care	<ul style="list-style-type: none"> • Multiple combinations possible <ul style="list-style-type: none"> – Kidney disease and diabetes and diagnostics and CV – Vascular protection and CV device – ARF genomics and diagnostics and GPRD genomics – Erythropoietin and oncology
Urology	<ul style="list-style-type: none"> • Overlap of ED/FSD drugs with diabetes franchise • Overlap of urologic pain drugs with analgesia and/or any primary care franchise

Source: Strategy retreat template

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PROPOSED COMMUNICATION OF DECISIONS**FOR DISCUSSION**

Audience	Key messages	Vehicle	Timing	Responsibility
<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/implications • Portfolio decisions (discovery and decisions) • Next steps 	<ul style="list-style-type: none"> • E-mail or conversation 	May 8	<ul style="list-style-type: none"> • J. Leiden
<ul style="list-style-type: none"> • R&D sub-teams 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/implications • Portfolio decisions • Timing of implementing portfolio decisions • Additional second set of synergy targets 	<ul style="list-style-type: none"> • R&D Steering Committee meeting 	May 8*	<ul style="list-style-type: none"> • J. Leonard • D. Norbeck • X. Frapaise
<ul style="list-style-type: none"> • VP TAs • Venture heads, global project management 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/implications • Portfolio decisions • Timing of implementing decisions • HR issues/implications 	<ul style="list-style-type: none"> • One-on-one or group meeting 	May 8	<ul style="list-style-type: none"> • J. Leonard

* Currently scheduled for May 10 but could not be moved up to communicate decisions

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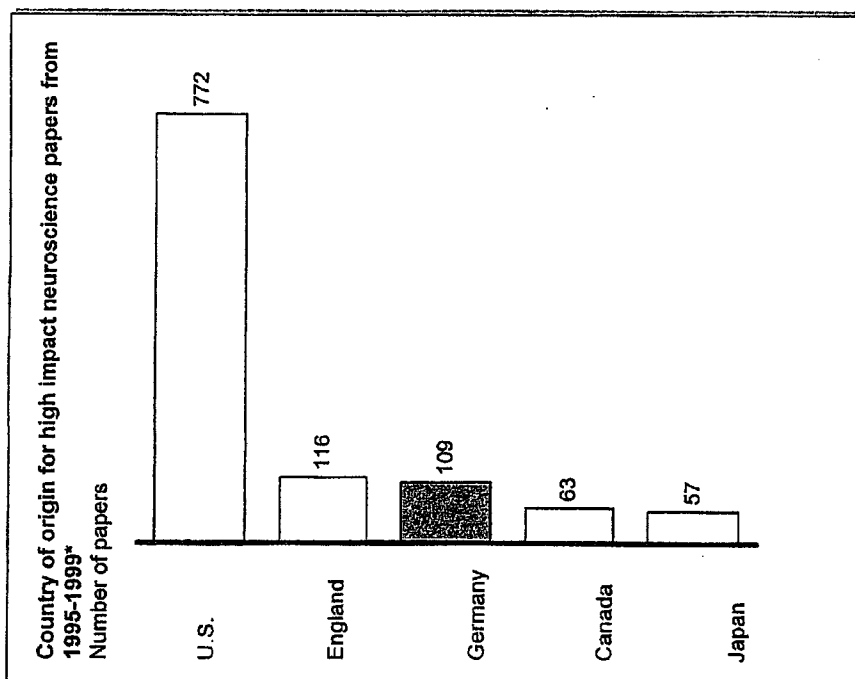
PROPOSED COMMUNICATION OF DECISIONS (CONTINUED)**FOR DISCUSSION**

Audience	Key messages	Vehicle	Timing	Responsibility
<ul style="list-style-type: none"> • Venture/project teams 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/ implications • Portfolio decisions • Timing of implementing decisions • HR issues/implications 	<ul style="list-style-type: none"> • Venture team meetings 	By May 11	<ul style="list-style-type: none"> • Venture heads
<ul style="list-style-type: none"> • Discovery TA heads 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/ implications • Portfolio decisions • Timing of implementing decisions • HR issues/implications 	<ul style="list-style-type: none"> • One-on-one or group meeting 	May 8	<ul style="list-style-type: none"> • D. Norbeck
<ul style="list-style-type: none"> • Discovery project teams 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/implications • Portfolio decisions • Timing of implementing decisions • HR issues/implications 	<ul style="list-style-type: none"> • Project or TA team meetings 	By May 11	<ul style="list-style-type: none"> • Discovery TA heads
<ul style="list-style-type: none"> • Site leaders <ul style="list-style-type: none"> – ABC – Japan – Ludwigshafen – Mt. Olive – Nottingham 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/implications • Portfolio decisions • Timing of implementing decisions • HR issues/implications 	<ul style="list-style-type: none"> • One-on-one conversations 	By May 11	<ul style="list-style-type: none"> • J. Leiden

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TOP NEUROSCIENCE RESEARCH CENTERS

PRELIMINARY



German institutes with most high impact neuroscience papers from 1995-1999*		
Institute	Location	Number of papers
Max Planck Institute of Psychiatry	Munich, German	14
Max Planck Institute of Medical Research	Heidelberg, Germany	11
University of Freiburg	Freiburg, Germany	8
University of Munich	Munich, Germany	6
University of Tübingen	Tübingen, Germany	6
Christian-Albrechts-University of Kiel	Kiel, Germany	5
Max Planck Institute for Brain Research	Frankfurt, Germany	4
University of Heidelberg	Heidelberg, Germany	4
Central Institute for Mental Health	Mannheim, Germany	3
Max Planck Institute for Biophysical Chemistry	Göttingen, Germany	3
Max Planck Institute for Neurobiology	Martinsried, Germany	3
Technical University of Munich	Munich, Germany	3
University of Göttingen	Göttingen, Germany	3
University of Konstanz	Konstanz, Germany	3

* The high-impact papers are determined by frequency of citation – the 200 most frequently cited papers through 2000 from each of the following years, 1995, 1996, 1997, 1998, and 1999, were then determined. The list was generated by identifying the institute affiliated with the author(s) of these papers. The neuroscience publications compiled by the Institute for Scientific Information tend to be focused more on basic science (e.g., *Nature*) than clinical science (e.g., *New England Journal of Medicine*)

Source: Institute for Scientific Information (ISI); interview with manager of contract research at ISI

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PROJECTS BY TA

\$ Millions

APRIL UPDATE

TA	Project	2001 shut-down cost			
		2001 budget	Internal	External	Total
• Anti-infectives	• ABT-492	27.8	8.0	1.1	9.1
	(Quinolone)	88.5	27.1	32.8	59.9
	• ABT-773 (Ketolide)	14.9	3.1	7.3	10.4
	• Clarithromycin	52.0	16.6	15.5	32.1
	• Kaletra	4.8	1.5	0.1	1.6
	• Omnicef	4.0	1.4	0.3	1.7
	• Ritonavir				
	Total	192.0			
• Cardiology/ thrombosis	• Clivarine	3.8	1.7	1.7	3.3
	• Darusentan	27.0	2.7	6.7	9.5
	• Fenofibrate	2.0	1.4	-	1.4
	• Propafenone	9.3	5.7	3.6	9.3
	Total	42.1			
• Gastro-intestinal	• AV-224	4.4	0.4	1.5	1.9
	• Ganaton	0.0	1.2	0.4	1.6
	Total	4.4			

Source: GPRD Finance

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PROJECTS BY TA (CONTINUED)

\$ Millions

APRIL UPDATE

TA	Project	2001 budget	2001 shut-down cost		
			Internal	External	Total
• Immunology	• D2E7	102.7	?	?	?
	• Gengraf	2.5	0.7	1.2	1.9
	• Hokunalin Tape	0.0	0.0	0.0	0.0
	• J695	14.0	3.6	6.6	10.2
	• SEGARD	11.9	6.0	5.9	11.9
	Total	131.1			
• Metabolic	• Sibutramine	26.0	7.5	13.9	21.4
	• T4/T3	9.3	?	?	?
	Total	35.3			
• Neurology	• ABT-089 (ADHD)	0.9	0.6	0.0	0.6
	• BSF 201640	(2.3)	0.0	0.0	0.0
	• Depakote	24.1	10.6	5.5	16.1
	Total	22.7			
• Oncology	• ABT-510 (TSP-1)	10.8	5.9	0.2	6.1
	• ABT-518 (MMP1)	7.1	4.4	0.2	4.6
	• ABT-627 (Endothelin)	38.4	12.6	2.1	14.7
	• ABT-751 (Anti-mitotic)	8.3	3.5	0.0	3.5
	Total	64.6			

Source: GPRD Finance

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APRIL UPDATE

PROJECTS BY TA (CONTINUED)
\$ Millions

TA	Project	2001 budget	2001 shut-down cost		
			Internal	External	Total
• Other	• Synthroid	1.7	?	?	?
	• Vicoprofen	1.2	?	?	?
	• Tarka	1.1	?	?	?
	Total	4.0			
• Pain	• ABT-594	9.3	7.7	1.1	8.8
	• ABT-963 (COX II)	1.3	1.1	0.1	1.2
	• Dilaudid	14.4	?	?	?
	• Hydrocodone	3.4	?	?	?
	Total	28.4			
• Renal	PEG-Hirudin	21.7	?	2.2	?
	Total	21.7			
• Urology	ABT-598 (kco)	5.0	1.4	0.0	1.4
	BSF 420627	4.9	?	?	?
	Total	9.9			
	Grand total	556.3			

Source: GPRD Finance

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PRELIMINARY

IMPACT OF R&D SYNERGIES IDENTIFIED ON LUDWIGSHAFEN

Function	Synergy opportunity	Cost savings		Cumulative headcount reductions in Ludwigshafen		Comments
		2001	2002	2001	2002	
CMC	• Close Ludwigshafen chemical development plant	3.9	9.3	37	37	• Achieving savings identified in 2001 is closely tied to timing of headcount reductions
	• Scale up formulation facility of Ludwigshafen	(0.3)	(5.0)	(23)	(63)	• Significant headcount additions in CMC could be key factor in Workers' Council negotiations
Data management and statistics	• Reduce development operations headcount	0.1	0.2	2	2	• Impact of current plan is likely limited
Discovery	• Close high throughput screening at Ludwigshafen	0.7	4.2	29	29	• Headcount reductions identified are more than any other function • Plan is to consolidate operations in Abbott Park
Drug safety	• Move contracted work in Europe to Abbott Park	1.3	1.9	—	—	• Savings dependent upon directing project teams to use internal (Abbott Park) resources
	• Reduce radiochemistry operations	0.2	0.7	5	5	
IM&T	• Eliminate non-critical IT positions	0.1	0.3	3	3	• Most savings are from disentanglement of services from BASF corporate
Medical affairs*	• Reduce health outcomes personnel	0.1	0.2	2	2	• Impact of current plan is likely limited

* Excludes initiatives related to AEGIS conversion and reductions in Phase IV trials
Source: Synergy templates; sub-team leaders; team analysis

CH-CH-228013-013jb/aARD

PRELIMINARY

IMPACT OF R&D SYNERGIES IDENTIFIED ON LUDWIGSHAFEN (CONTINUED)

Function	Synergy opportunity	Cost savings		Cumulative headcount reductions in Ludwigshafen		Comments
		2001	2002	2001	2002	
Phase 1	• Increase utilization of Ludwigshafen Phase 1 unit	0.1	0.2	—	—	• Savings dependent upon ability to control location of Phase 1 trials
	• Reduce pharmacokinetic contractor	—	0.3	—	1	
	• Reduce clinical pharmacology headcount	0.1	0.5	4	4	
	• Defer planned AQS upgrades in Ludwigshafen	0.1	—	—	—	
Regulatory affairs/QA	• Reduce head count in Ludwigshafen and operating expenses in regulatory affairs	0.1	0.3	3	3	• Current plan is to consolidate some regulatory and QA activities in Abbot Park
Venture/global team management	• Reduce head count in project management	0.2	0.5	4	4	• Impact of current plans is likely limited
Total		6.7	13.6	66	27	

Source: Synergy templates; sub-team leaders; team analysis

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CH-CH-228013-013jb/aaRD

APRIL UPDATE

HPD R&D BUDGET

\$ Millions

TA	Project	2001 budget
Perioperative and intensive care	• Precedex	5.7
	• PCA III	2.9
	• Corlopam	6.9
	• Rapid dissolve-RP Scherer	3.1
	• Controlled release hydrocodone	4.4
	• Long acting local/systemic anesthetic	1.0
	• Masimo	0.3
	• All other	3.7
	• Total	28.0
Renal care	• Zemplar Phase IV	0.7
	• Zemplar capsules	10.0
	• Zemplar pediatric ESRD	1.3
	• Calcijex pediatric ESRD	0.6
	• Renal care new candidates	1.4
	• Erythropoiesis product feasibility	2.6
	• Pharmacosmos – next generation IV iron	2.5
	• Pronova (Omacor)	–
	• All other	5.0
	• Total	24.1

Source: HPD finance

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CH-CH-228013-013jb/aaRD

HPD R&D BUDGET (CONTINUED)

\$ Millions

APRIL UPDATE

TA	Project	2001 budget
Oncology/anti-infective	• Na Pro Paclitaxel	-0.8
	• SuperGen – Rubitecan	–
	• Antisoma – Theragyn	7.8
	• ABT-773	–
	• All other	0.2
	• Total	7.2
Vascular	• Perclose	13.7
	• Restenosis inhibition (Biocompatibles)	1.7
	• Low molecular weight heparin delivery	1.4
	• rUK/Abbo utilization	–
	• Abbokinase	10.8
	• rUK	7.4
	• Total	34.9
Critical care	• Q2+	2.3
	• All other	1.2
	• Total	3.5

Source: HPD finance

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CH-CH-228013-013jb/aaRD

HPD R&D BUDGET (CONTINUED)

\$ Millions

APRIL UPDATE

TA	Project	2001 budget
EDDS	<ul style="list-style-type: none"> • Plum at therapy module • Plum at multi-channel • Gemstar • All other • Total 	1.2 4.8 1.2 — 7.3
Acute care injectables	<ul style="list-style-type: none"> • Milrinone IV • Amiodarone • Epinephrine Syringe • All other • Total 	0.2 0.1 1.4 4.8 6.5
All other	<ul style="list-style-type: none"> • Opus • Aegis • Other development • Operations support • Capitalization impact • Total R&D/medical 	1.5 0.3 17.6 45.6 -9.0 161.0

Source: HPD finance

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DEPOSITION EXHIBIT 11

PLT'S EXHIBIT FS



Jessica Hopfield
05/06/2001 02:42 PM

To: Patricia Weber/NJE/NorthAmerica/MCKINSEY@MCKINSEY
cc:
Subject: Please print and put in mail folder

----- Forwarded by Jessica Hopfield/NJE/NorthAmerica/MCKINSEY on 05/06/2001 02:43 PM -----



Jessica Hopfield
05/06/2001 02:41 PM

To: Jeff.leiden@abbott.com
cc: Michael Williams/NJE/NorthAmerica/MCKINSEY@MCKINSEY, David Keeling/CHI/NorthAmerica/MCKINSEY@MCKINSEY, Dick Ashley/CHI/NorthAmerica/MCKINSEY@MCKINSEY, (bcc: Jessica Hopfield/NJE/NorthAmerica/MCKINSEY)
Subject: R&D Strategy Retreat Output

Jeff,

Below are a few items from our Friday afternoon session for you to pass on as appropriate to the group. We will be working with Bob and John over the next few days to be sure they have all the costs and headcount information from the sub-teams so that the project and location roll-ups can be completed.

There are two issues I wanted to follow-up on. First is CMC where the team **has** made real progress over the last few weeks through workshops and has considered the issues raised on Friday (e.g., maintaining expertise, ability to move equipment) to develop a plan with significant savings. You will see this material later this month but Michael Williams can give you a sneak preview if you have concerns about where the team is.

The second issue is LU as a site for CNS. While returning the cardiology protein chemists and channel types to CNS is straightforward (and Germany certainly has a tradition in membrane biophysics), attracting true worldclass talent to LU to run the program may be tough. My background just happens to be in the area of Abbott focus (I received a PhD and was a post-doc with Torsten Weisel and Paul Greengard at Rockefeller on protein phosphorylation of the nicotinic acetylcholine receptor and third messenger modulation of dopamine activity) and I am hard-pressed to think of hot-talent with good drug instincts willing to move to Germany. You may want to be careful about committing too large a group to the site until you have a better read on this and Jim Sullivan's willingness to travel extensively.

- Notes by TA and project with next steps - most are Jim or John to-dos.



Strategy Retreat Next Steps by Project.c

- Previous action items from the March 7-9 development review. Group already has this but many items



are pending NEXT STEPS - development portfolio prioritization

- 2001 Project-related savings identified



2001 Savings Identified.doc



- Discovery structure and headcount



Proposed Discovery Organization.d

Jessica

R&D Strategy Retreat Next Steps by TA and Project

Anti-infectives	Overall	Jim to examine Chiron HCV patent issue Jim to continue Pharmaset discussions (cell culture, model development) Bob and John to determine what to do with 6 pre-clinical headcount at LU
	Ritonavir	Bob to determine \$4 m expenditure John to kill all spending possible
Urology	ABT – 598	Continue until POP/clear Phase II a results are in
	BSF 420627	Still pending task force assessment
Oncology	Overall	Jim to assess acquisition of Ilex and possible development partners such as BMS Discovery and development to continue; Bob and Steve charged with developing revised plan to focus on anti-angiogenesis only and to push two compounds into man quickly and cheaply
	ABT – 627	Convene 1 day panel with prostate and cancer trial experts and then return to EC
	ABT – 510	Finish Phase I, do not progress to Phase II until entire program/strategy is approved
	ABT – 518	Terminate

Cardiology	Overall	Jim to assess viability of spin-out; develop asset list and portfolio list asap HPD to look at LU pig stent models in next two weeks
	Darusentan	Jim to sell – start process in next 90 days Slow all activities
	PEG-Hirudin	Will probably stop pending expert panel
Neuroscience	Overall	Jim Sullivan to recruit leader over next one to two years; start headhunting now
	ABT – 089	Dan to develop plan for accelerating
	Dilaudid	Bob to determine Phase IV activities in costs
	ABT – 594	Pending until EC review Phase II results; consider IV formulation
	ABT – 963	John to convene external panel to look at GI, Alz, and other indications Jim to continue to look for partner
	Vicoprofen	All activities not yet started to be stopped
Diabetes/Met	Overall	Need for small core team to look for external opportunities and compounds Jim to continue Novo discussions
	Sibutramine	John to appoint someone to “bulldog” studies to keep costs down Phase IV study review to be held
	T4/T3	All work to stop until program is reviewed John and Bob to evaluate how to reduce spend

GI	AU-224	Ed to complete marketing assessment
	Ganaton	John and Chris to develop plan to do inexpensively
Immunosci	Overall	Jim to work with HGS to identify targets for mAbs
		Jim to continue Genentech discussions
		Bob and Dan to develop recommendation on how to organize kinase platform
	D2E7	John to develop costs on Crohn's
	J695	Iris to work with John and Bob on spending
	Segard	Stop all U.S. work; continue Europe
Renal	Overall	Need for focused program around leveragable assets
		Analysis needed on what therapies likely to impact early and late stages of disease
		Consider bringing in expert to run program

INITIAL PORTFOLIO PRIORITIZATION

Project	Priority	Next steps	Responsibility	Timing	C- continue P- pending T- terminate
Anti-infectives					
ABT-492	C	<ul style="list-style-type: none"> Address safety issues (including QTc) with internal/ expert review Determine how many indications at launch (pay back) Consider trading with Daiichi Halt any new expenditure 	• J. Leonard	-	
HSR-903	T		• J. Tyree	-	
ABT-773	C	<ul style="list-style-type: none"> Assess side effects issues with expert review (QTc and liver tox.) Ensure all drug interactions are adequately covered Assess relative to Ketek 	• J. Leonard	-	
Urology					
BSF 420627	P	<ul style="list-style-type: none"> Set up task force to address issues and bring back plan to senior management <ul style="list-style-type: none"> Reasons for failure of the SKB ETa/b antagonist Design short (~4 week) PoP trial for symptom relief Rationale for sustained release formulation Nature of the Schwarz Pharma relationship 	• J. Leonard	• By May	
Hypothyroidism					
T3/T4	P	<ul style="list-style-type: none"> Assess most appropriate ratio Gain FDA feedback on study design Determine ex-US market attractiveness (price) 	• J. Leonard	• By May	
Asthma					
Hokunalin tape	P	<ul style="list-style-type: none"> Conduct market research on acceptance by different patient segments Determine how to position against long acting beta agonists and combination inhalers Evaluate opportunity to gain complete access to the patch technology 	• A. Higgins/ E. Fiorentino	• May	
			• J. Tyree		

0

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing	C- continue P- pending T- terminate
Oncology ABT-510	C	<ul style="list-style-type: none"> Pursue proof of concept Leverage TAP knowledge of angiogenesis product development (appropriate endpoints) 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> As planned 	
ABT-751	C	<ul style="list-style-type: none"> Pursue proof of concept Use echocardiogram to monitor potential cardiotoxicity Resolve potent drug manufacturing approach 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> As planned 	
ABT-518	Hold	<ul style="list-style-type: none"> Wait for May results from Pfizer (will save ~\$1mill) and re-evaluate Halt all further expenditure 	<ul style="list-style-type: none"> CMC group Senior management 	<ul style="list-style-type: none"> May 	
Rubitecan	P	<ul style="list-style-type: none"> Significant clinical rework required (funded by partner)- further in-depth review required Make a proceed decision when 2Q data available 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> By May 	
Theragyn	P	<ul style="list-style-type: none"> Negative initial scientific perspective - further in-depth review required, e.g., <ul style="list-style-type: none"> Determine if there is a PoC to support claim Address GMP issues Determine best control to demonstrate efficacy Re-look at partnership contract 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> By May 	
ABT-627	C	<ul style="list-style-type: none"> Seek alternative funding (e.g., NCI) before starting major trial If move ahead <ul style="list-style-type: none"> Determine how to ensure NDA filing in 2004 Get FDA input since survival not primary endpoint Harmonize US and EU study design and inputs Consider partnership (e.g., BI or established oncology player) 	<ul style="list-style-type: none"> J. Tyree J. Leonard, P. Nisen 	<ul style="list-style-type: none"> By May ASAP 	
			<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> By May 	

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
Cardiology/ thrombosis Darusentan (LU 135252)	Hold	<ul style="list-style-type: none"> • Continue currently budgeted funding for next 6 months • Do not start any new trials (e.g., hypertension planned for May) • If proceed, plan for pilot to look at effects in sperm and tetragonogenicity • Consider out-license or swap 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • Ongoing
LU 208075	Hold	<ul style="list-style-type: none"> • Continue currently budgeted funding for next six months • Look at Myogen deal • Out-license or swap 	<ul style="list-style-type: none"> • J. Tyree • Project team 	<ul style="list-style-type: none"> • ASAP • ongoing
Levosimendan	C	• Conduct detailed expert panel review for trial design	• J. Leonard	• May
PEG-hirudin	P	• Set up expert panel for commercial assessment (is diabetes an option?)	• E. Ogunro	• By May
Ancrod	T	• Identify out-licensing opportunities	• J. Tyree	• TBD
Urokinase	P	<ul style="list-style-type: none"> • Market research required on open cath • Match versus tPA in dose-ranging studies to determine efficacy 	• E. Fiorentino	• By May
Pro-urokinase	C	• Identify opportunities to speed up program	• Project team	• TBD
Clivarine	C	<ul style="list-style-type: none"> • Assessment by HPD (review previous evaluation and new trial data) • Understand finished product manufacturing cost 	• E. Ogunro	• By May
Rythmol SR	C	<ul style="list-style-type: none"> • Continue filing • Verify if package is likely approvable • Assess commercial attractiveness in a generic market 	• B. Dempsey	
			• Project team	• Ongoing

C- continue
P- pending
T- terminate

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Neuroscience				
ABT 594	P	<ul style="list-style-type: none"> • Await results from ongoing PII trial – probable T • Project team to develop decision criteria for go/no go 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • June/ July
ABT 963	C	<ul style="list-style-type: none"> • Identify a co-development/co-promotion partner (TAP high on list) • Evaluate benefits of the long half life in pain and cancer (including additional physician market research) • Explore cancer prophylaxis and Alzheimer's indications 	<ul style="list-style-type: none"> • J. Tyree • Project team 	<ul style="list-style-type: none"> • TBD
BSF 201640	P	<ul style="list-style-type: none"> • Complete review of all schizophrenia NCEs with expert panel • Complete staffing of internal project team, but halt further expenditure beyond looking at hepatic tox. and QTc • Understand Novartis contract and level of interest 	<ul style="list-style-type: none"> • I. Loew • Project team 	<ul style="list-style-type: none"> • By May
BSF 190555	P	<ul style="list-style-type: none"> • Complete review as above • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • J. Tyree • I. Loew 	<ul style="list-style-type: none"> • As above
BSF 74398	C	<ul style="list-style-type: none"> • Allow DevCo to continue development • Re-look at relationship with DevCo 	<ul style="list-style-type: none"> • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
Diluadid Oros	Hold	<ul style="list-style-type: none"> • Return to ALZA or out-license to other interested partner 	<ul style="list-style-type: none"> • J. Tyree 	<ul style="list-style-type: none"> • TBD
Hydrocodone	C	<ul style="list-style-type: none"> • Assess regulatory pathway • Understand DEA impact on manufacturing 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • By May
Bimoclomol (ABT 822)	P	<ul style="list-style-type: none"> • Await data from ongoing trial in April before deciding whether to continue - probable T • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • April

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Gastro-enterology Ganaton	P	<ul style="list-style-type: none"> • Conduct U.S. commercial assessment with TAP • Assess how to position in Europe versus generics and implications for comparative trial • Develop model to assess spend at different termination points 	<ul style="list-style-type: none"> • E. Fiorentino 	<ul style="list-style-type: none"> • By June
TU-199	T	<ul style="list-style-type: none"> • Terminate outside Japan 	<ul style="list-style-type: none"> • Bob Funck 	<ul style="list-style-type: none"> • By May
AU-224	C	<ul style="list-style-type: none"> • Develop and pursue a small PoC trial in humans ASAP (consider niche indication first and leverage Marlene's expertise) • Conduct market research on IBS versus constipation (including pricing) 	<ul style="list-style-type: none"> • Project team • Project team • E. Fiorentino 	<ul style="list-style-type: none"> • Immediate • ASAP
Immunology D2E7	C	<ul style="list-style-type: none"> • Conduct intensive product review <ul style="list-style-type: none"> - 2 day meeting with J. Lennard's group (already in process) - ½ day session with senior management group • Important actions include <ul style="list-style-type: none"> - Approach FDA for fast track and compassionate use - Develop strategy for DMARD claim in first submission - Assess need for Enbrel assay to detect HAHAs - Assess delivery device options - Evaluate additional indications (e.g., Psoriasis, Crohns, heart failure) and pediatric program - Profile Celltech product - Assess impact of additional IV program on reimbursement • Develop list of potential marketing partners for quids 	<ul style="list-style-type: none"> • J. Leonard • Various • J. Tyree 	<ul style="list-style-type: none"> • By May • By May

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Immunology (continued) Segard	Hold	<ul style="list-style-type: none"> • Continue filing in EU and Canada • Put on hold in US – consider creating a small team in the US to analyse data, propose smaller PII study • Research pricing, marketing and Phase IV plans in Europe • Look at TNF-alpha levels retrospectively to see stratification with IL-6 • Assess manufacturing strategy • Identify potential out-licensing opportunities (Genentech) 	<ul style="list-style-type: none"> • Project team • J. Leonard 	<ul style="list-style-type: none"> • Ongoing
J695	P	<ul style="list-style-type: none"> • Decide on most attractive indications from Abbott and partner perspective • Discuss with partner ways to share the various indications and potential for TNF-alpha combinations • Add commercial person to the project team by this week 	<ul style="list-style-type: none"> • J. Tyree • E. Fiorentino • J. Tyree • Ongoing 	<ul style="list-style-type: none"> • ASAP

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
PIV programs				
Clarithromycin	C	• None identified	-	-
Omnicef	C	• Talk to partners	• J. Tyree	-
Kaletra	C	• None identified	-	-
Norvir	C	• None identified	-	-
Meridia	Hold	<ul style="list-style-type: none"> • Conduct commercial assessment for CNS and depression (P&L) • Assess combination therapy with fibrates • Assess outcomes trial design to meet preferred commercial profile; determine payback 	<ul style="list-style-type: none"> • B. Dempsey, J. Arnott, E. Fiorentino • Project team 	<ul style="list-style-type: none"> • ASAP
Uprima	C	<ul style="list-style-type: none"> • Ensure no redundant trials with TAP in Europe • Halt all activities 	• Project team	• Ongoing
Trandolapril patch	T		• Project team	• Immediate
Trandolapril "Invest" clinical program	P	• Review trial in more detail (reduce complexity and risk)	• E. Fiorentino	• By May
Other trandolapril trials	C	• Continue "Create", "Peace" and "Benedict" trial programs	• Project team	• Ongoing
Fenofibrate	C	• Develop co-formulation ideas with Meridia and statins (including assessment of sales and costs)	• Project team	-
Depakote	C	• None identified	-	-
Gengraf	C	• None identified	-	-

2001 Savings Identified (\$ millions)

Ritonivir	4.0
ABT – 518	2.5
LU 135252	8.5
PEG – Hirudin	11.2
Dilaudid	14.0 (needs further assessment)
Vicoprofen	.9
Sibutramine	4.6 (needs further assessment)

Additional opportunities in:

HPD Pharma

Dex

Levo

Proposed Discovery Organization

1. Neuroscience	400
• Pain – US based	
• Psych – LU based	
2. Diabetes/metabolism	125
3. Anti-infectives	125
• novel rib	
• pump inhibitor	
• HCV instead of HIV	
4. Immunoscience	200
• mAb platform	
• RA (large and small molecule)	
• kinases	
5. Oncology	200

Note: headcount numbers include Japan but do not include HPD

2001 Savings Identified (\$ millions)

Ritonivir	4.0
ABT – 518	2.5
LU 135252	8.5
PEG – Hirudin	11.2
Dilaudid	14.0 (needs further assessment)
Vicoprofen	.9
Sibutramine	4.6 (needs further assessment)

Additional opportunities in:

HPD Pharma

Dex

Levo

Hopfield Deposition Exhibit 23

D's Exhibit GJ



Beatrice
Rendenbach - Mueller /KNOLL
-AG/BASF@KNOLL -AG

04/10/2001 11:19 AM

Kevin P Constable/LAKE/PPRD/ABBOTT@ABBOTT, James
Sullivan/LAKE/PPRD/ABBOTT@ABBOTT, Laura
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Marasco/LAKE/PPD/ABBOTT@ABBOTT, Christopher J
Silber/LAKE/PPRD/ABBOTT@ABBOTT, Bruce
McCarthy/LAKE/PPRD/ABBOTT@ABBOTT, Kenneth
Sommerville/LAKE/PPRD/ABBOTT@ABBOTT, Kevin P
Constable/LAKE/PPRD/ABBOTT@ABBOTT, Arthur A
Hancock/LAKE/PPRD/ABBOTT@ABBOTT, Michael W
Decker/LAKE/PPRD/ABBOTT@ABBOTT, Michael D
Meyer/LAKE/PPRD/ABBOTT@ABBOTT, Nigel
To Livesey/LAKE/Al/ABBOTT@ABBOTT, Steven E
Townsend/LAKE/PPRD/ABBOTT@ABBOTT, Ingrid
Weber/KNOLL-AG/BASF@KNOLL-AG, Liliane
Unger/KNOLL-AG/BASF@KNOLL-AG, Karsten
Wicke/KNOLL-AG/BASF@KNOLL-AG, Roberto
Carceneri-De-Prati/KNOLL-AG/BASF@KNOLL-AG, Pat
Needham/KNOLL-UK/BASF@KNOLL-UK, Ian
Pardon/KNOLL-UK/BASF@KNOLL-UK, Katherine A
Tracy/LAKE/PPRD/ABBOTT@ABBOTT, Elizabeth
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cc

bcc

Subject FW: Pharma Strategy Retreat <Virus checked>

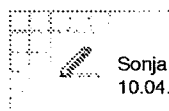
Dear all,

I have just received the attached templates for the strategy retreat from Matthias Lutz. They have been distributed today in the Cardiovascular team. Please have a look at these documents and start to complete missing information as we have discussed last week. I will meet with Jim later today and on Thursday and will agree with him on the next steps. So far I have no information on the deadlines for submission. As soon as there is more information available, I will let you know.

Kind regards,

Beatrice

----- Weitergeleitet von Beatrice RendenbachMueller/KNOLL-AG/BASF am 10.04.2001 17:18 -----



Sonja Laube
10.04.2001 17:05

An: Beatrice Rendenbach-Mueller/KNOLL-AG/BASF@KNOLL-AG
Kopie:

Thema: FW: Pharma Strategy Retreat <Virus checked>

----- Weitergeleitet von Sonja Laube/KNOLL-AG/BASF am 10.04.2001 17:07 -----



"Lebold, Suzanne APX" <LeboldSA2@HPD.Abbott.com> am 10.04.2001
14:46:24

An: Matthias Luz/KNOLL-AG/BASF





CONFIDENTIAL

Meeting Mechanics

 Abbott Laboratories

Global Pharmaceutical R&D strategy retreat

March 2-4, 2001

Highly Confidential

ABBT294221

ISSUES TO BE RESOLVED

Issue	Perspective
1. Which TA's should be presented and what how should the scope for each TA be defined?	<ul style="list-style-type: none"> • Shown on page 2
2. How should Knoll in-market and pipeline products be allocated by TA?	<ul style="list-style-type: none"> • Proposed alignment on pages 3-4
3. Who should attend the meeting and who should be responsible for creating each TA presentations?	<ul style="list-style-type: none"> • Group of ~40-50 R&D and commercial managers will be present throughout the TA presentations • TA presenters not nominated as part of this group should stay only for their TA discussion (list of presenters on pages 5-6) • Executive group will meet independently at the end of each day and for an additional half day • Executive group will also hold a separate 1 day meeting to discuss broader portfolio, budget and organizational implications
4. What should the overall agenda be for the meeting	<ul style="list-style-type: none"> • Current proposal on pages 7-9 <ul style="list-style-type: none"> – Day1: pharma overview, TA presentations – Day 2: TA presentations (continued) – Day 3: TA presentations (continued) – Day 4: Half day to decide on business shape
5. How to ensure templates and guidelines are clearly communicated and sufficient consistency is achieved?	<ul style="list-style-type: none"> • Templates and high level guidelines should be communicated ASAP (see attachment) • McKinsey can follow up with team leaders to provide additional context/answer questions (but not to drive analysis/document preparation)

1

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ABBT294222

SELECTION AND SCOPE OF INDIVIDUAL TA PRESENTATIONSPRELIMINARY

Ventures/TAs	In-scope areas (not inclusive)
1. Anti-infectives	• Antibacterials, anti-virals, anti-parasitics, antifungals
2. Neuroscience	• Stroke, Parkinson's, epilepsy, migraine, Alzheimer's • Psychiatric diseases, Attention deficit disorder
3. Pain/NSAIDs	• Neuropathic pain, chronic pain, NSAIDs • Narcotic analgesia, other analgesia, acute pain
4. Cardiovascular/ thrombosis	• Hypertension, CHF, hyperlipidemia, MI • Stroke, unstable angina, anti-coagulants
5. Urology	• BPH, erectile dysfunction, incontinence
6. Diabetes/obesity	• Diabetes, diabetic complications, obesity
7. Oncology	• All tumors and all pharmaceutical approaches
8. Immunoscience	• RA/OA, psoriasis, transplantation, MS, Crohn's, sepsis, asthma
9. Anesthesia	• Injectibles, inhalation agents, neuromuscular blockers, anti-emetics, anxiolytics etc
10. Renal Care	• Vitamin D analogues, kidney transplantation, erythropoiesis, iron therapy, EPO

ALLOCATION OF PRODUCTS BY THERAPEUTIC AREA - IN MARKETPRELIMINARY

Therapeutic Area	x-Abbott products	x-Knoll products
1. Anti-infectives	Omnicef, Claforan, Biaxin/Klacid, Biaxin/Klacid XL, erythromycin, Metronidazole, Vancomycin, Tosuxacin, Pediazole Gengraf, Kaletra, Norvir, Certiva, Synagis	erythromycin
2. Neuroscience	Depakote, Cylert, Gabitril, Depacon, magnesium sulphate, ProSom	Akineton, Cerebrolysin, Exelon, Zoleptil
3. Pain/ inflammation	Tranxene, Fentanyl, Ketorolac, morphine sulfate, A-Hydrocord/ Ampethapred, Actiq	Dilaudid, Vicoprofen, Vicodin, Brufen
4. Cardiovascular/thrombosis	Loftyl, Tricor, Labetalol, Micardis, Digoxin, Diltiazem, Bospres, Simdax	Rythmol, Tarka, Isoptin, Mavik, Gopten/Mavik, Clivarine
5. Urology	Hytrin, Flomax	
6. Diabetes/obesity/ metabolism	Thymone (thyroid hormone)	Meridia, Synthroid (thyroid hormone)
7. Oncology	Lupron (TAP)	
8. Immunology/inflammation (including asthma)	Mobic, Avonex, Zyflo (asthma), Xopenex, (asthma), Bremax (asthma)	Hokunalin (asthma)
9. Anesthesia	Ultiva, Ultane/Sevorane, Ethrane, Amidate, Forane, Anzemet, butorphanol, Chirocaine, sufentanil citrate, Atracurium, Tracrium, Nimbox, Nuromax, metoclopramide, Mivacron, Precedex	
10. Renal care	Zemplar, Calcijex	

ALLOCATION OF PRODUCTS BY THERAPEUTIC AREA - PIPELINE**PRELIMINARY**

Therapeutic Area	x-Abbott projects	x-Knoll projects
1. Anti-infectives	Spectracef (TAP), ABT-492, ABT-773 PETT compounds, Clevudine, DAPD, MIV-606, Coactinon, Coviracil, Synagis, ABT-677, L-FMAU	HSR-903 (Phase III, Japan)
2. Neuroscience	Depakote ER, Idebenone, ABS/NPS, ABT-418, MKC-231, Protirelin, TAK-147, ABT-089, ABS-103, NPS-1776	BSF-190555, BSF-201640, BSF-74398
3. Pain	Hydrocodone	Dilaudid CR
4. Cardiovascular/thrombosis	Antexan, TAK-044, ABT-120, Seratrodast, A-74187, ABT-187	Trandolapril, LU-208075, Viprinex, Peg-Hirudin, LU-135252, Rythmol SR (Ludwigshafen projects) BSF-420627
5. Urology	ABT-232, NS-49, ABT-598	
6. Diabetes/obesity/metabolism	Bimoclomal, ABT-594, Actos, Chrysalin, Voglibose (hyperglycemia)	T4/T3 (hypothyroidism)
7. Oncology	ABT-510, ABT-518, ABT-751, CEP-2563 dihydrochloride, E7010, AGM-1470, CEP-701, TNP-470, YM529, Rubitecan, ABT-627, HMG1, Theragyn, ABT-828, FTI Backup, TSP-2, Integrin and ICAM modulators	
8. Immunoscience	ABT-963, TAK-603, TMX-67, LJP-394, Atreleuton and VML-530 (asthma), TAK-661 (dermatitis, asthma)	Thyrogen, J695, D2E7, Segard (all Worcester R&D), Hokunalin tape (asthma)
9. Anesthesia		
10. Renal care	EPO generic	

PROPOSED TEAMS TO DEVELOP TA PRESENTATIONSPRELIMINARY

TAs	Co-leaders (joint team)	Other team members
1. Anti-infectives	<ul style="list-style-type: none"> • E. Sun - clinical • S. Chang - discovery • TBD - commercial 	• N/a
2. Anti-viral	<ul style="list-style-type: none"> • E. Sun - clinical • S. Chang – discovery • TBD - commercial 	• n/a
3. Neuroscience	<ul style="list-style-type: none"> • Iris Loew-Frickel - clinical • J. Sullivan – discovery • TBD - commercial 	• n/a
4. Pain	<ul style="list-style-type: none"> • Charlie McLeskey (HPD) • ohn Heden (HPD) – commercial • TBD - discovery 	• n/a
5. Cardiovascular/ thrombosis	<ul style="list-style-type: none"> • Suneil Gupta (HPD) - clinical • Iris Loew-Friedrich - clinical • F. Frickel – discovery • S. Leibold (HPD) – commercial • John Toner (HPD) - discovery 	• Mary Szela (HPD)
6. Urology	<ul style="list-style-type: none"> • M. Verlinden - ? • J. Sullivan – discovery • TBD - commercial 	• n/a

PROPOSED TEAMS TO DEVELOP TA PRESENTATIONS (Continued)

PRELIMINARY

TAs	Co-leaders (joint team)	Other team members
6. Diabetes/obesity	<ul style="list-style-type: none"> • I Loew-Friedrich - clinical • T. Oppenorth - discovery • TBD - commercial 	<ul style="list-style-type: none"> • N/a
7. Oncology	<ul style="list-style-type: none"> • P. Nixen/L. Vitek (HPD) - clinical • S. Fesik - discovery • TBD - commercial 	<ul style="list-style-type: none"> • Tom Moore (HPD) - com • Scott Toner (HPD) - com • Dave Ostrow (HPD) - clin
8. Immunology/ immunology	<ul style="list-style-type: none"> • I Loew-Friedrich - clinical • R. Kamen - discovery • TBD - commercial 	<ul style="list-style-type: none"> • N/a
9. Anesthesia	<ul style="list-style-type: none"> • Charlie McLeskey (HPD) - clinical • George Maliekal (HPD) - commercial • TBD - discovery 	<ul style="list-style-type: none"> • Mary Szela (HPD) - com • John Toner (HPD) - dis
10. Renal Care	<ul style="list-style-type: none"> • Bruce McNutt (HPD) - clinical • Susan Rodriguez (HPD) -commercial • TBD - discovery 	<ul style="list-style-type: none"> • Loreen Mershimer (HPD)

PROPOSED AGENDA - Day 1*~8-9 hrs of presentations/discussion per day*

Topic	Presenter/ Facilitator	Timing
Introduction		
• Introduction (Aspirations for the new Abbott Pharma business, meeting objectives, key issues to be resolved)	• Jeff Leiden	• 30 mins
• Review of the overall global pharma opportunity	• TBD (McKinsey)	• 2 hrs
– Relative attractiveness of major TAs and disease areas		
– Comparison of major regions (US, Europe, Japan)		
– Current position of Abbott relative to competition, in terms of portfolio and capabilities		
Individual TA discussions		
• Neuroscience	• TA team	• 2 hr
Lunch		
• Anti-infectives	• TA team	• 2 hr
Executive session	• Jeff Leiden/ McKinsey	• 1.5 hrs

PROPOSED AGENDA - Day 2

Topic	Presenter/ Facilitator	Timing
Individual TA discussions (Continued)		
• Pain/NSAIDS	• TA team	• 1.5 hr
• Cardiology/thrombosis	• TA team	• 2 hr
Lunch		
• Urology	• TA team	• 1.5 hr
• Diabetes/obesity	• TA team	• 1.5 hr
Executive session	• Jeff Leiden/ McKinsey	• 1.5 hr

PROPOSED AGENDA - Day 3

Topic	Presenter/ Facilitator	Timing
Individual TA discussions (Continued)		
• Oncology	• TA team	• 2 hr
• Immunoscience (RA, Crohns, Psoriasis, MS, transplantation, sepsis)	• TA team	• 2 hr
Lunch		
• Anesthesia	• TA team	• 1.5 hr
• Renal Care	• TA team	• 1.5 hr
Executive session	• Jeff Leiden/ McKinsey	• 1.5 hr

PROPOSED AGENDA - Day 4 (HALF DAY EXECUTIVE SESSION)

Topic	Presenter/ Facilitator	Timing
Facilitated discussion on business shape • Drive to conclusion from Days 1-3 (synthesis from executive sessions) - What is the relative attractiveness of the TAs? - How many TAs should Abbott focus on? - What areas of science and what disease should each TA focus on? - What additional technology technology platforms that we should consider acquiring? - What core areas of discovery and development that need to be upgraded? - What are the licensing needs of each TA?	• TBD (McKinsey?)	• 3 hrs.
Lunch		

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Templates for TA Presentations



Global Pharmaceutical R&D strategy retreat
March 4-6, 2001

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EXECUTIVE SUMMARY – NATURE OF THE OPPORTUNITY

- Highlight why the TA should be attractive for Abbott
 - Global market size, growth
 - Key market trends and growth drivers out to 2010
 - Competitor landscape
 - Abbott's position

EXECUTIVE SUMMARY – RECOMMENDATIONS

Disease focus	Drug class focus	Discovery target focus
<ul style="list-style-type: none">• E.g., asthma•••	<ul style="list-style-type: none">• E.g., anti-inflammation•••	<ul style="list-style-type: none">• E.g., leukotriene antagonists•••

CONTENTS

Commercial outlook

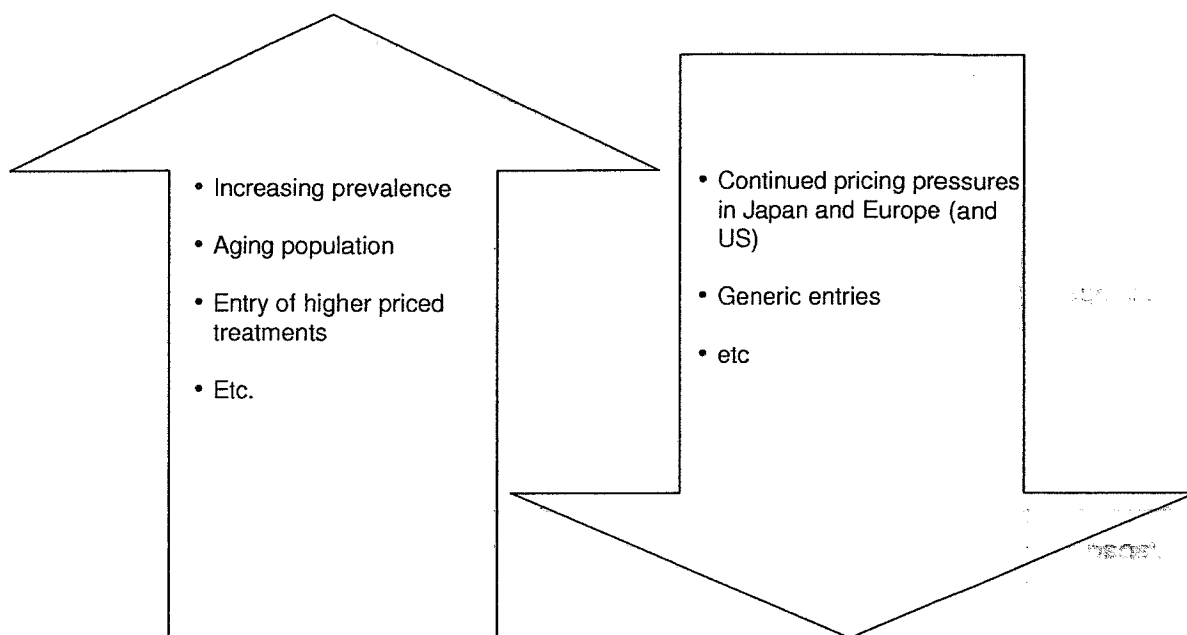
- Market drivers over next 10 years
- Epidemiology across major regions
- Current TA sales by disease and drug class
- Major market trends across the TA (to 2010)
- Projected market growth by disease area (or drug class)

Technical outlook

Abbott position

MARKET DRIVERS MOVING FORWARD

Global TA drivers



EPIDEMIOLOGY ACROSS THE TA

US

- Who
- How many
- Treatment rates

Europe

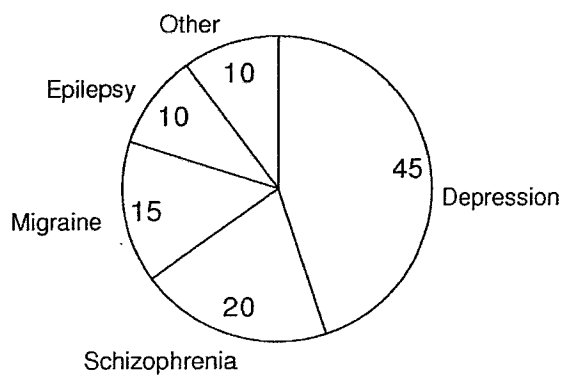
Japan

TA GLOBAL SALES BY DISEASE AND DRUG CLASS - 2000

\$Millions; percent

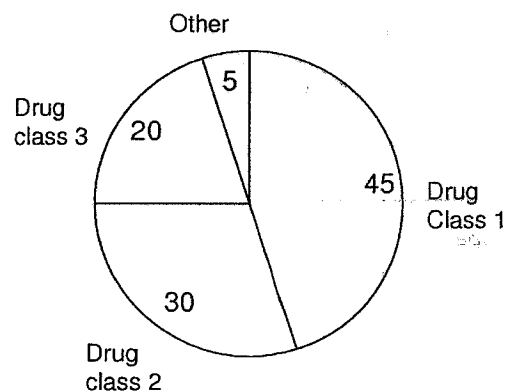
Sales by disease area

100% = \$___mill



Sales by drug class

100% = \$___mill



Key issues - diseases

- (relative attractiveness, pricing differential)
-
-

Key issues - drug class

- (e.g., growing/shrinking classes, price differential)
-
-

Source:IMS

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MAJOR MARKET TRENDS TO 2010

	Current situation	→	Projected situation in 2010
US	<ul style="list-style-type: none"> • Epidemiology • Patient trends • Physician trends • Pricing and reimbursement • Competition 		<ul style="list-style-type: none"> • • • •
Europe	<ul style="list-style-type: none"> • Highlight differences to US 		<ul style="list-style-type: none"> • •
Japan	<ul style="list-style-type: none"> • Highlight differences to US 		<ul style="list-style-type: none"> • •

PROJECTED GLOBAL MARKET GROWTH OF TA

\$ Millions

Major "swing-factors"

Upsides	Downsides
<ul style="list-style-type: none"> 	<ul style="list-style-type: none">

- Disease1
- Disease2
- Disease 2
- All others

CAGR %

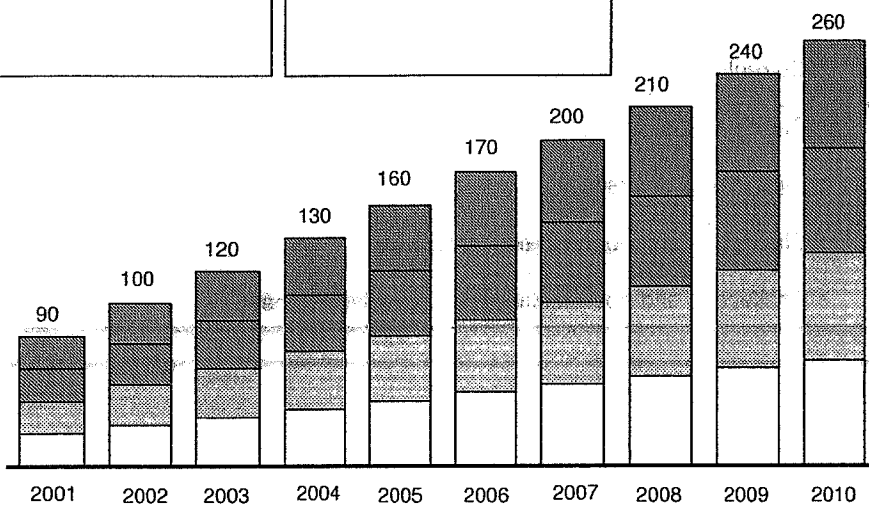
10%

8%

8%

5%

15%



* Compound annual growth rate

Source: Consensus estimates; project team projections

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CONTENTS

Commercial
outlook

**Technical
outlook**

- Disease overview
- Current treatment approach
- Current unmet needs
- Future medical practice
- Challenges and opportunities in discovery
- Challenges and opportunities in product development

Abbott
position

DISEASE OVERVIEW

- Etiology and pathophysiology of key disease states within the TA
- Level of current understanding
-

OVERVIEW OF CURRENT TREATMENT APPROACH

-
-
-
-

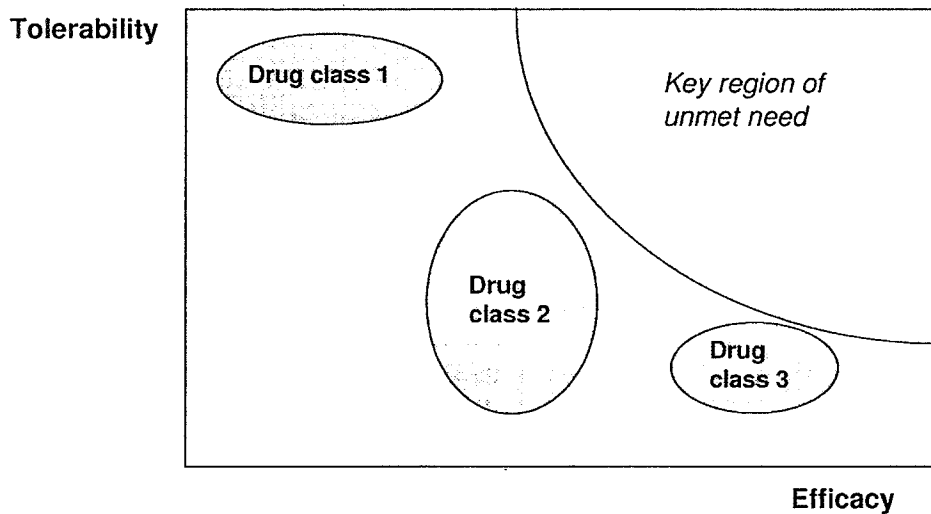
MAJOR UNMET NEEDS

30A320 Y8 4 1/2 10000 0.1-0.5

Category	Major unmet needs
1. Prevention	<ul style="list-style-type: none"> • •
2. Diagnosis	<ul style="list-style-type: none"> • •
3. Treatment	
– Efficacy	<ul style="list-style-type: none"> • •
– Safety	<ul style="list-style-type: none"> • •
– Compliance	<ul style="list-style-type: none"> • •

Breakdown into specific
diseases areas where
necessary

MAJOR UNMET NEEDS – BY DISEASE



- Consider plotting unmet need if helpful to present unmet needs
- This page is an example

FUTURE MEDICAL PRACTICE 2010 BY DISEASE

	Current practice	→	Future practice (2010)
Hypertension	<ul style="list-style-type: none"> • Prevention, diagnosis • Drug, device, surgical treatment preferences • Mode of administration • etc 		<ul style="list-style-type: none"> • New therapeutic approaches • etc
CHF			<ul style="list-style-type: none"> • •
Hyperlipidemia			<ul style="list-style-type: none"> • •

DISCOVERY OPPORTUNITIES AND CHALLENGES



Issue	Assessment	Rationale
1. Are viable/tractable targets currently available?		•
2. Are attractive sources of new targets available?		•
3. How powerful are current target validation strategies?		•
4. Do viable <i>in vitro</i> models of the diseases exist?		•
5. Do viable <i>in vivo</i> models exist (e.g., transgenics)?		•
6. How predictive are pre-clinical models?		•
7. Strength of applicable discovery expertise at Abbott		•

DISCOVERY OPPORTUNITIES AND CHALLENGES

Viable targets

 Part of current
Abbott portfolio

Potential targets	Scientific rationale
1. E.g., ICE, VEGF	•
2.	•
3.	•
4.	•

DISCOVERY OPPORTUNITIES AND CHALLENGES

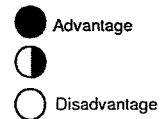
Sources of new targets

☐ Part of current
Abbott portfolio

Source	Scientific rationale
1. e.g., genomics, proteomics	• •
2.	• •
3.	• •
4.	•



DISCOVERY OPPORTUNITIES AND CHALLENGES







- ADD SMALL NUMBER OF CHARTS (NO MORE THAN 2-3) TO HIGHLIGHT SPECIFIC ISSUES AS REQUIRED

PRODUCT DEVELOPMENT OPPORTUNITIES AND CHALLENGES

Issue	Assessment	Rationale
1. Are viable proof-of-concept methodologies available?	○	•
2. Is patient recruitment a major obstacle?	◐	•
3. Are clinical trial guidelines available?	◑	•
4. Is trial methodology easy/difficult?	◐	•
5. Are validated outcome measures available?	●	•
6. Is placebo or comparator response rate high?	◑	•
7. Is there major adverse experience liability?	◑	•

PRODUCT DEVELOPMENT OPPORTUNITIES AND CHALLENGES (Continued)

 Advantage
 Disadvantage

Issue	Assessment	Rationale
1. Level of investment required (trial size, length, complexity)		•
2. Level of Abbott clinical development expertise across the TA		•
3. Is the regulatory path well established (across major markets)?		•
4. Is the indication recognized by regulators in US, Europe, Japan?		•
5. Overall regulatory risk of development?		•
6. Level of Abbott regulatory expertise across the TA		•

DEVELOPMENT OPPORTUNITIES AND CHALLENGES☐ Abbot presence

Attractive drug classes and NCEs in clinical development

Attractive drug class	Lead compounds	Scientific rationale
1. NSAIDs	<ul style="list-style-type: none">• Compound 1 (Abbott)• Compound 2 (Pfizer)	•
2.	•	•
3.	•	•
4.	•	•

PRODUCT DEVELOPMENT OPPORTUNITIES AND CHALLENGES

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- ADD SMALL NUMBER OF CHARTS (NO MORE THAN 2-3) TO HIGHLIGHT SPECIFIC ISSUES AS REQUIRED

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CONTENTS

Commercial
outlook

Technical
outlook

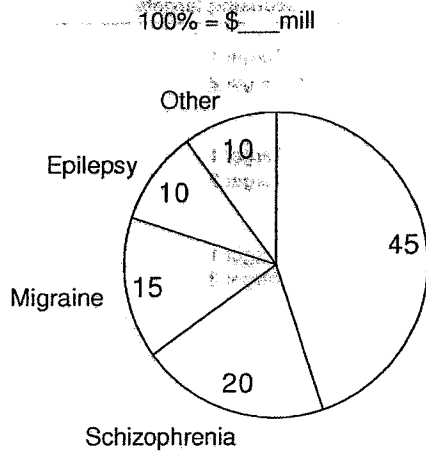
**Abbott
position**

- Current Abbott sales
- Abbott's current portfolio and budget allocation across the TA
- Upside scenario (sales potential; what we need to achieve the upside)

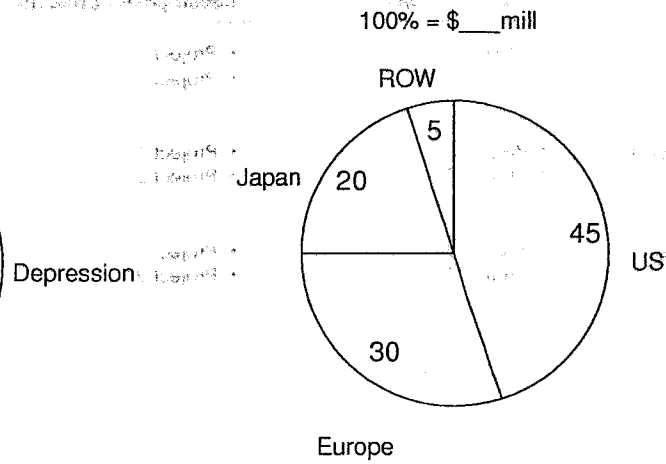
ABBOTT GLOBAL SALES BY DISEASE AND REGION - 2000

\$Millions; percent

Sales by disease area



Sales by region



Key issues - diseases

- (e.g., major franchises for Abbott; leadership positions, unique capabilities)
-
-

Key issues - region

- (e.g., rationale for geographic spread, high growth regions for Abbott)
-
-

* Include Abbott and Knoll products

Source:IMS

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CURRENT R&D PROJECTS AND TARGETS

Disease	Discovery projects	Development projects	Licensing targets
Epilepsy	<ul style="list-style-type: none">• Project 1• Project 2	<ul style="list-style-type: none">• Project 1• Project 2	<ul style="list-style-type: none">• Target 1• Target 2
Parkinson's	<ul style="list-style-type: none">• Project 1• Project 2	<ul style="list-style-type: none">• Project 1• Project 2	<ul style="list-style-type: none">• Target 1• Target 2
Migraine	<ul style="list-style-type: none">• Project 3• Project 4	<ul style="list-style-type: none">• Project 1• Project 2	<ul style="list-style-type: none">• Target 1• Target 2
etc			

- Only include projects and targets which are in the current plans
- Include both Knoll and Abbott portfolio for the TA

CURRENT R&D BUDGET ACROSS THE TA - 2001

\$ Millions

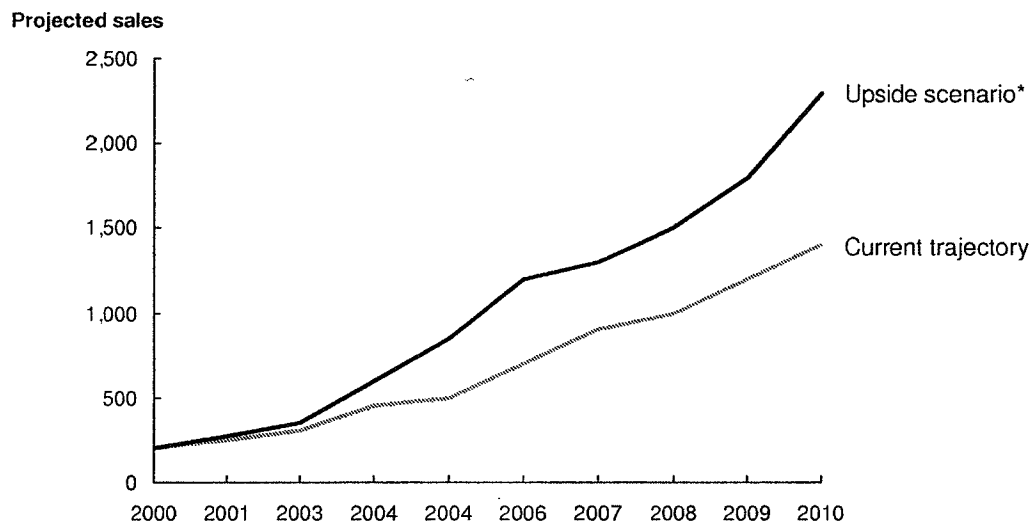
Disease	Discovery projects	Budget	Development projects	Budget
Epilepsy	• Project 1	5.0	• Project 1	2.0
	• Project 2	6.7	• Project 2	1.3
Parkinson's	• Project 1	10	• Project 1	10.5
	• Project 2	1.1	• Project 2	22.3
Migraine	• Project 3	2.2	• Project 1	1.7
	• Project 4	4.2	• Project 2	0.5
etc				
		Total \$25 mill	Total \$44 mill	

- Only include projects and targets which are in the current plans
- Include both Knoll and Abbott portfolio for the TA
- Only use disease categorization if available

GROWTH SCENARIOS FOR THE TA

ILLUSTRATIVE

\$ Millions



1. *Upside scenario*; TA to provide specific growth opportunities to drive a more aggressive (realistic) growth scenario
2. *Current trajectory*; Provide consolidated sales projection for all currently supported in-market products and development/pre-clinical research projects

* Include major enhancements of current in-market products

GROWTH OPPORTUNITIES TO ACHIEVE THE UPSIDE SCENARIO

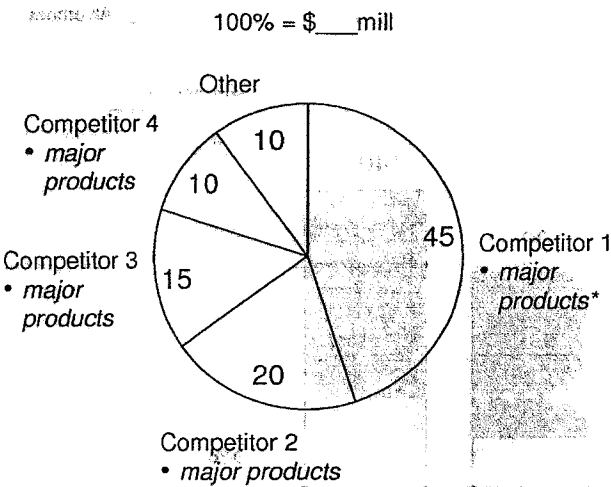
	Brief description of upside opportunity (examples given below)	What we need to capture the opportunity
Discovery	<ul style="list-style-type: none"> • Set up a major ICE research program • Strengthen combinatorial chemistry expertise in specific area 	<ul style="list-style-type: none"> • E.g., Resources, new technologies, licensing activity, infrastructure
Development	<ul style="list-style-type: none"> • Pursue new indications for a product already in the pipeline 	
In-licensing	<ul style="list-style-type: none"> • License-in the following type of compound (specify mechanism of action) • Establish partnership for specific technology 	<ul style="list-style-type: none"> •
Synergies with other Abbott franchises	<ul style="list-style-type: none"> • Drug-device combinations • Drug fixed-dose combinations 	<ul style="list-style-type: none"> •
<ul style="list-style-type: none"> • Only discovery, development and in-licensing opportunities • Initiatives should sum up difference between current trajectory and upside scenario 		

**EXAMPLES OF BACK-UP PAGES
- APPENDIX**

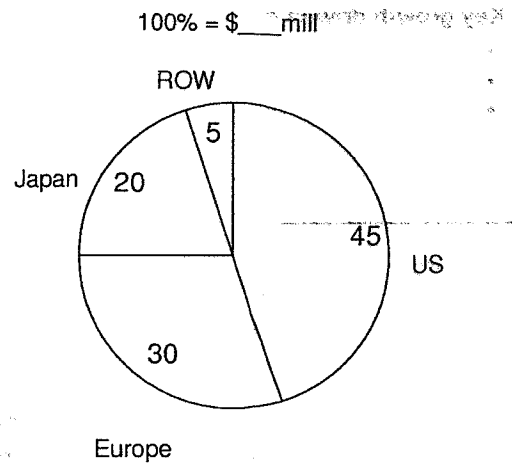
TA GLOBAL SALES BY COMPETITOR AND REGION - 2000

\$Millions; percent

Sales by competitor



Sales by region



Key issues - competitor

- (e.g., major moves, emerging winner)
-
-

Key issues - regions

- (e.g., pricing differential, difference in market preferences)
-
-

* List the top 1-2 products by competitor
Source: IMS

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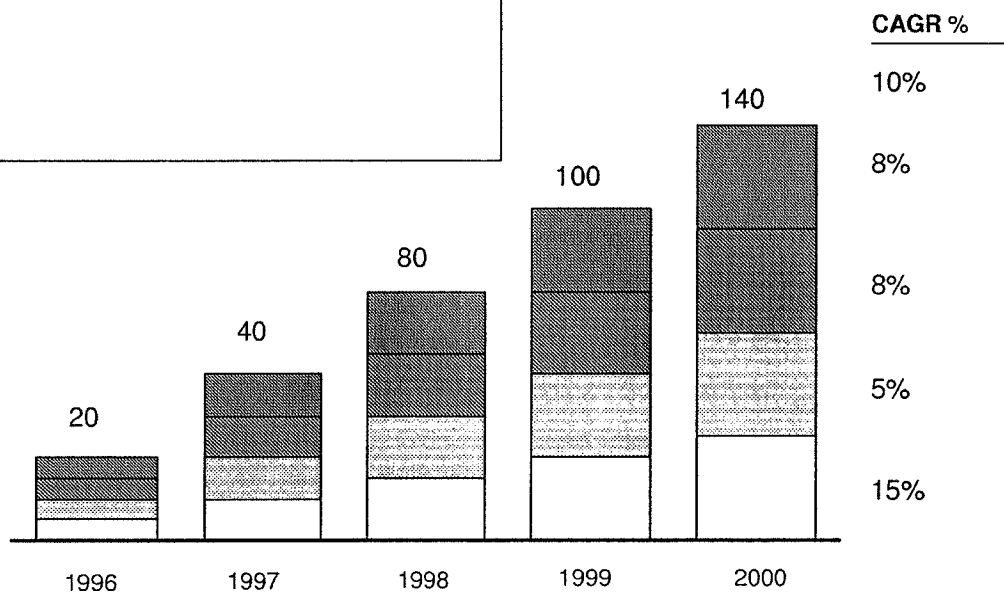
HISTORICAL MARKET GROWTH OF THERAPEUTIC AREA

\$ Millions

Key growth drivers over past 5 years

-
-
-

Disease1
Disease2
Diseas3
All others



* Compound annual growth rate

Source: IMS

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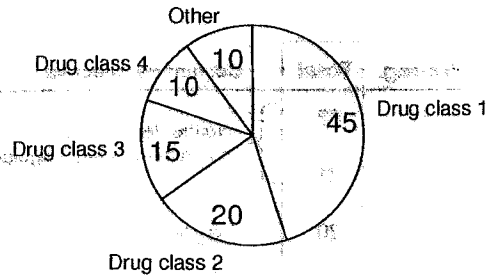
DISEASE 1 SUMMARY - 2000

\$Millions; percent

REPEAT FOR TOP 2-3 DISEASES
IF APPLICABLE - May go in appendix

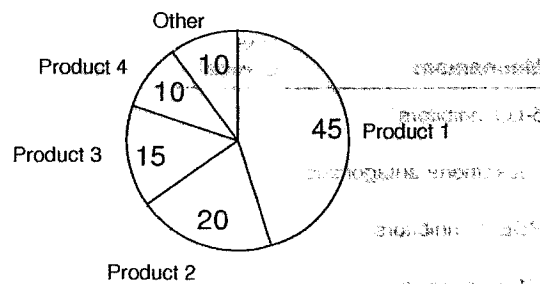
Sales by drug class

100% = \$___mill



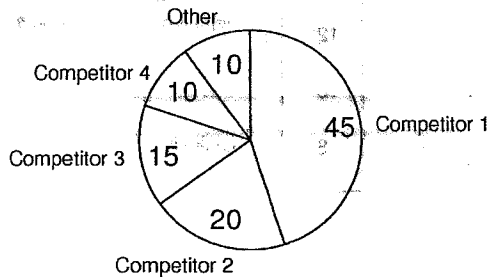
Sales by product

100% = \$___mill



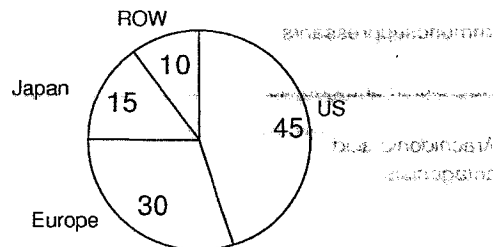
Sales by competitor

100% = \$___mill



Sales by region

100% = \$___mill



Source:IMS

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OVERVIEW OF PROJECTS BY MECHANISM OF ACTION*

ASTHMA EXAMPLE - 1997

Mechanism	Pre-clinical	Phase I	II	III	Pre-reg.	Total	Current Perspective
5-LO inhibitors	7	6	5	3	1	22	} Neither likely to be much better than Singulair
Leukotriene antagonists	9	4	7	1		21	
PDE IV inhibitors	12	2	5	1		20	Gastric side effects
H1 antagonists	9	1	4	1		15	Japan only
Immunomodulators	10	3	1			14	} Most likely to produce significant new products
Immunosuppressants	6		5	1		12	
Neurokinin antagonists	6	1	3			10	Maybe long term
Arachidonic acid antagonists	2	3	1	1	1	8	Unlikely

* Include Abbott + Knoll
Source: R&D Insight: Pharma Projects etc

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OVERVIEW OF PROJECTS BY COMPANY*

ASTHMA EXAMPLE - 1997

Company	Pre-clinical	Phase I	II	III	Pre-reg.	Total
Pfizer	6	1	1			8
SKB	3		4	1		7
Astra	3	2	1			6
Bayer	1		3		1	5
Fujisawa	2		3			5
Pharmacia Upjohn	3	2				5
Sanofi	2	1	1	1		5
Yamanouchi	2	2		1		5
BI	1		1	2		4
Glaxo Wellcome	2	2				4
Merck	4					4
RPR	2		1	1		4
Zeneca	2	1	1			4
Other companies	~80	~15	~40	5	5	4
						~145
Total ~110 companies	~100	~27	~56	11	6	~210

* Include Abbott + Knoll combined
Source: R&D Insight; Pharma Projects etc

DESCRIPTION OF MAJOR PROJECTS BY COMPANYASTHMA EXAMPLE

From Phase I to Pre-registration

Company	Mechanism of action	Drug	Phase	Other indications
Bayer	TXA2 antagonist	Ramatroban	• Prereg. (Japan) • Phase III (Ger.)	• Allergic rhinitis
Abbott	5-Lipoxygenase inhibitor	Zileuton	• Prereg. (Canada) • Launched (US)	• Tried several, no success so far
Kyoura Hakko	Leukotriene B4 antagonist	Olopatadine	• Prereg. (Japan) • Phase II (US, Ger.)	• Conjunctivitis (launched in US) • Allergic rhinitis and urticaria (prereg. in Japan)
Schering Plough	Arachidonic acid antagonist	Mometasone	• Prereg. (US, UK)	• Allergic seasonal and perennial rhinitis (launched) • Psoriasis (prereg. US)
Sepracor	Beta 2 agonist	Levosalmolamol neb. suspension	• Prereg. (US) • Phase III (global)	
Sankyo	TXA2 synthetase inhibitor	Imitrodest sodium	• Prereg. (Japan)	
Shionogi	TXA2 antagonist	Domitroban	• Prereg. (Japan)	• Allergic rhinitis

* Including Abbott + Knoll combined
Source: R&D Insight; Pharma Projects etc

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OVERVIEW OF NEW ABBOTT PORTFOLIO - IN MARKET

\$ Millions

Products	Indications	Major competitors	US Sales (2000)	ROW Sales (2000)	Sales growth % (2000-05)	Comments
Product 1	Indication 1 Indication 2	Competitor 1	100	100	10%	<ul style="list-style-type: none"> • Major growth opportunities, challenges • Patent expiry etc
Product 2	Indication 2 Indication 4	Competitor 2 Competitor 3	75	75	(5%)	•
Product 3	Indication 3	Competitor 3	45	45	45%	•

OVERVIEW OF NEW ABBOTT PORTFOLIO – DEVELOPMENT PIPELINE

\$ Millions

Project	Indications	Competitors	Phase	Launch year	Peak Sales	Comments
Project 1	Indication 1	Competitor 1	III	2004	700	<ul style="list-style-type: none"> • Major growth opportunities, challenges • Patent expiry etc
Project 2	Indication 2 Indication 5	Competitor 2	II	2005	600	•
Project 3	Indication 3	Competitor 3	II	2006	600	•

OVERVIEW OF NEW ABBOTT PORTFOLIO – RESEARCH PIPELINE

Program	Stage of most advanced lead	Potential indications	Comments
Program 1	Pre-clin	Disease 1 Disease 2	• •
Program 2	Lead identification	Disease 2	
Program 3	Pre-clin	Disease 3 Disease 4	

IN-LICENSING TARGETS – BY DISEASE AREA

Target (mechanism)	Originator	Phase	US Launch	Peak Sales \$mill	Benefit to TA franchise
Product 1	Company A	P III	2004	500	• • •
Product 2	Company B	P II	2003	850	
Product 3	Company B	P II	2003	2,000	





OVERVIEW OF MAJOR PARTNERSHIPS

	Partner	Compounds/ technologies	Potential indications	Description
Existing	Partner 2	Compound 1	Disease 1 Disease 2	• •
	Partner 2	Technology 2	Disease 2	
	Partner 3	Co-promotion with compound X	Disease 3 Disease 4	
Targets	Target 1	Acquisition	Disease 1	
	Target 2	Academic institute	Disease 2	

Include major commercial, development and research collaboration

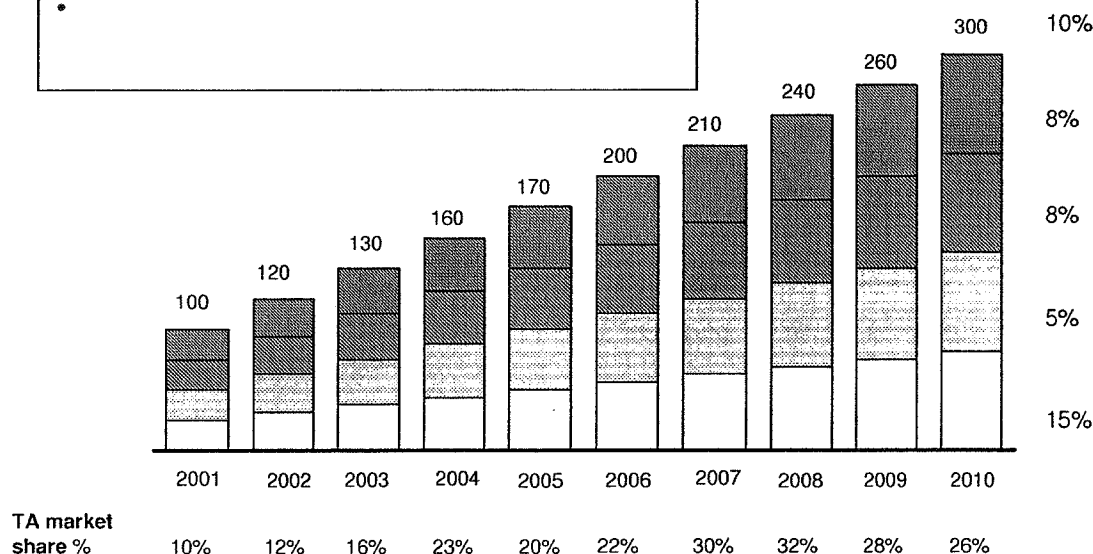
CURRENT ABBOTT SALES TRAJECTORY BY DISEASE AREA*

\$ Millions

 Disease1
 Disease2
 Disease 2
 All others

Major growth drivers

-
-
-

CAGR %

* Includes Abbott and Knoll in-market and pipeline products and currently planned R&D projects

Source: Team projections

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PLANNED ACTIVITIES TO HIT THE CURRENT TRAJECTORY

Disease	Targets	Launch	Peak year sales impact \$mill	Risk adjusted NPV \$mill
Epilepsy	• In-market products	2003	250	50
	• Products in PI-PIII developments	2004	100	25
	• Early stage development projects that will be launched by 2010	2004	250	120
Parkinson's	• In-market products	2003	250	50
	• Products in PI-PIII developments	2004	100	25
	• Early stage development projects that will be launched by 2010	2004	250	120
Migraine				

- In-market products and pipeline projects which are in the current plans
- Include both Knoll and Abbott portfolio for the TA

GROWTH OPPORTUNITIES BEYOND CURRENT TRAJECTORY

Growth initiatives	Brief description (examples given below)	Launch	Peak year sales \$mill	Risk adjusted NPV \$mill
Initiative 1	<ul style="list-style-type: none"> Additional internal NCEs or new indications that are not supported in the current budget/plan 	2003	250	50
Initiative 2	<ul style="list-style-type: none"> Additional PIV programs for currently marketed products beyond current plan (new formulations, new indications etc) 	2004	100	25
Initiative 3	<ul style="list-style-type: none"> Launches in additional countries beyond current plan 	2004	250	120
Initiative 4	<ul style="list-style-type: none"> New compounds identified by discovery that could reach market prior to 2010 In-licensing activities (with real targets identified) 	2005	500	200

- Only discovery, development and in-licensing opportunities
- Initiatives should sum up difference between current trajectory and upside scenario

CURRENT TREATMENT APPROACH

ASTHMA EXAMPLE - 1997

Asthma

Impact	Approach	Major products	Commentary
Quick symptomatic relief	Short acting beta 2 agonist	Proventil, Ventolin, generic albuterol	Drug of choice for acute symptoms of bronchoconstriction and preventative treatment prior to exercise for exercise-induced bronchospasm, taken as needed. Well served group except for cardiac side-effects due to co-stimulation of beta 1 receptors.
	Anticholinergics	Atrovent, generic ipratropium	Relief of acute bronchospasm through inhibition of muscarinic receptors. Does not block exercise-induced bronchospasm. May have additive effects to beta agonists but slower onset of action. Used for patients who are intolerant to beta agonists.
Long-term maintenance therapy	Steroids		
	- Inhaled steroids	Azmacort, Vancoril, Aerbid, Flovent, Beclovent	Long-term prevention of symptoms through suppression of inflammation. Inhibit cytokine production, adhesion receptor activation and inflammatory cell migration/activation. Risk of local side-effect (thrush, cough) and systemic absorption at high dosages. Mouth washing, spacers and DPIs reduce risks.
	- Oral steroids	Generics	For short-term (3-10 day) bursts to gain prompt control or for long-term prevention in severe persistent asthma. Lowest effective dosage used to minimize side-effects.
	NSAID		
	- Cromolyn	Intal, generic	Long-term prevention of symptoms; may modify inflammation. Preventative treatment prior to exercise or allergen exposure. Stabilize mast cell membranes, inhibit activation and mediator release from eosinophils and epithelial cells and modulate chloride channel function.
	- Nedocromil	Tilade	Therapeutic response may be delayed 2-4 weeks; nedocromil has unpleasant taste for some, but is 6-8x more potent than cromolyn.
	Xanthines, phosphodiesterase antagonists	TheoDur, SloBid, generic theophylline	Long-term symptom control, especially nocturnal. Smooth muscle relaxation from phosphodiesterase inhibition and maybe adenosine antagonism. May also effect immune cell migration and mucociliary clearance. Narrow therapeutic range with serum concentration monitoring required.
	Long acting beta 2 agonist	Serevent (salmeterol)	Long-term prevention of symptoms especially nocturnal. Prevention of exercise-induced bronchospasm. Salmeterol (but not formoterol) has a slower onset of action (15-30 min). Both have longer duration (12 hours) than short-acting beta agonists. Not a replacement for inhaled steroids.
	Leukotriene Modulators		
	- 5-lipoxygenase inhib.	Zylo (zileuton)	Both for long-term control and symptom prevention in mild persistent asthma. Accolate's advantages include Q-dosing and no requirement for liver monitoring
	- Receptor antagonist	Accolate (zafirlukast)	

Source:

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CURRENT PHARMACEUTICAL TREATMENT

ASTHMA EXAMPLE - 1997

Asthma

Strategy and drug class	Clinical activity/use	Mode of action	Typical delivery	Dosage
Bronchodilators				
Beta agonists	<ul style="list-style-type: none"> • Short acting: drug of choice for acute attacks and prevention of exercise-induced asthma • Long acting: slower onset of action/longer duration, for long-term prevention of attacks (especially nocturnal) and prevention of exercise induced bronchospasm 	<ul style="list-style-type: none"> • Selectively stimulate beta-2 receptors <ul style="list-style-type: none"> – Dilate airways by relaxing the smooth muscle – Decrease mucus secretion 	Inhaled	PRN; up to 8 puffs per day
Xanthines	<ul style="list-style-type: none"> • Less potent but longer duration of action <ul style="list-style-type: none"> – Prevention for nocturnal asthma – Severe cases uncontrolled on steroids/long acting beta agonists 	<ul style="list-style-type: none"> • Relax smooth muscle 	Oral (SR)	Titration of serum level
Anticholinergics	<ul style="list-style-type: none"> • 3rd line agent after steroids and long-acting beta agonists. Typically for the elderly and COPD 	<ul style="list-style-type: none"> • Block reflex bronchoconstriction and reduce smooth muscle tone 	Inhaled	1-2 puffs up to 12 times q 24
Anti-inflammatory				
Steroids	<ul style="list-style-type: none"> • Most effective broad spectrum anti-inflammatory agent. Maintenance prophylaxis of symptoms, reduce need for bronchodilators and improve long-term lung function • Side-effect profile limits usage of oral steroids 	<ul style="list-style-type: none"> • Modulate gene expression of inflammatory mediators <ul style="list-style-type: none"> – Anti-inflammatory – Decrease mucus secretion – Restore damaged epithelium 	Inhaled	<ul style="list-style-type: none"> • Short term oral 40-80 mg • Varies
NSAIDS				
Cromolyns	<ul style="list-style-type: none"> • Exercise induced asthma. Mildly effective for children and well tolerated 	<ul style="list-style-type: none"> • Mast cell stabilization 	Inhaled	20 mg q6hr
Leukotriene modulators				
<ul style="list-style-type: none"> – Leukotriene receptor antagonist – 5-lipoxygenase 	<ul style="list-style-type: none"> • Use is still emerging. Indicated for prophylaxis and chronic treatment of mild persistent asthma. More targeted effect than steroids, presently recommended as an adjunct to inhaled steroids, not a replacement 	<ul style="list-style-type: none"> • Receptor antagonist blocks leukotriene binding to cell surface receptors and 5-lipoxygenase inhibitors block synthesis of leukotrienes • Block Early-stage allergen response • Reduce late-phase response 	Oral	Accolate; 20mg q12hr Zylto; 600 mg q 6hr

Source: Decision Resources 11/96; Handbook of Pulmonary Drug Therapy (1996); Pink Sheet 12/96; The search for anti-inflammatory drugs, Adams and Merluzzi (1997)

CURRENT PHARMACEUTICAL TREATMENT – BRONCHODILATORY

ASTHMA EXAMPLE - 1997

Major drug class	Major indications	Major projects	Manufacturer	Global sales (2000) \$ Millions*	Sales growth 1998-00 %	Issues
Beta-2 agonists**						
Short acting	Asthma COPD	Proventil (albuterol)	Schering Plough		%	n/a
		Ventolin (albuterol)	GlaxoWellcome			n/a
		albuterol	Generic			Schering Plough sales of
Long acting	Asthma COPD	Serevent (salmeterol)	GlaxoWellcome			Longer acting, launched in 1995. Increased compliance with twice daily dosing.
Totals					%	
Xanthines	Asthma	Slo-bid (theophylline)	RPR			Side effects and blood monitoring reduce usage
		Theo-Dur (theophylline)	Schering Plough			
Totals						
Anticholinergics	Asthma COPD	Atrovert - MDI (ipratropium bromide)	BI			Most effective in COPD
Totals						

** Short acting Beta agonists: albuterol, terbutaline, perbactol, bitolterol (3-6 hrs) Long acting Beta agonists: salmeterol, formoterol
Source: IMS Retail and Provider Perspective: NDTI

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Meeting Mechanics



Global Pharmaceutical R&D strategy retreat
March 2-4, 2001

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MEETING OBJECTIVES

- To provide senior management with a common understanding of the portfolio and capabilities of the new Abbott across the major TAs, research technologies and geographies.
- To decide on the shape of the business moving forward in terms of high priority TAs, disease areas and scientific technology platforms
- This will be used to drive the following decisions
 - Areas of the business that require increased or decreased resources
 - Changes to licensing strategy and targets
 - Discovery and development sites
 - Development and marketing programs with devices and diagnostics

GENERAL QUESTIONS TO BE ADDRESSED AT THE RETREAT

- How many TAs should Abbott focus on?
- Which TAs should we focus on?
- Within each TA, what areas of science and what disease hold the greatest promise?
- Are there specific technology platforms that we should consider acquiring to accelerate our R and D programs?
- Are there core areas of discovery or development that we need to upgrade?
- How should we best integrate the BASF Pharma R and D sites and compounds into the Abbott GPRD organization?
- What are the licensing needs as opposed to the internal development needs of each TA?

ISSUES TO BE RESOLVED

Issue	Perspective
1. Which TA's should be presented and what how should the scope for each TA be defined?	<ul style="list-style-type: none"> • Proposal on page 4
2. How should Knoll in-market and pipeline products be allocated by TA?	<ul style="list-style-type: none"> • Proposed alignment shown on page 5, 6
3. Who should attend the meeting and who should be responsible for creating each TA presentations?	<ul style="list-style-type: none"> • Proposed attendance shown on page 7 and individual TA participants on pages 8-9. <ul style="list-style-type: none"> – Clinical team member should lead creation of presentation – Broader team of experts should provide necessary content
4. What should the overall agenda be for the meeting	<ul style="list-style-type: none"> • Current proposal on pages 10-12. <ul style="list-style-type: none"> – Day1: pharma overview, TA presentations – Day 2: TA presentations (continued) – Day 3: TA presentations (continued) – Day 4: Half day to decide on business shape and discuss organizational implications
5. How to ensure templates and guidelines are clearly communicated and sufficient consistency is achieved?	<ul style="list-style-type: none"> • Templates and high level guidelines should be communicated ASAP • McKinsey can follow up with team leaders to provide additional context/answer questions (but not to drive analysis/document preparation)

SELECTION AND SCOPE OF INDIVIDUAL TA PRESENTATIONS

Ventures/TAs	In-scope areas	PRELIMINARY
1. Anti-infectives	• Antibiotics	
2. Anti-viral	• HIV, Hepatitis B and C, RSV	
3. Neuroscience	• Stroke, Parkinson's, epilepsy, migraine, Alzheimer's • Psychiatric diseases, Attention deficit disorder	
4. Pain/NSAIDS	• Neuropathic pain, chronic pain, NSAIDs • Narcotic analgesia, other analgesia, acute pain	
5. Cardiovascular/ thrombosis	• Hypertension, CHF, hyperlipidemia, MI • Stroke, unstable angina, anti-coagulants	
6. Urology	• BPH, erectile dysfunction, incontinence	
7. Diabetes/obesity	• Diabetes, diabetic complications, obesity	
8. Oncology	• All tumors and all pharmaceutical approaches	
9. Immunology/ inflammation	• RA/OA, psoriasis, transplantation, MS, Crohn's, sepsis, asthma	
10. Anesthesia	• Injectibles, inhalation agents, neuromuscular blockers, anti-emetics, anxiolytics etc	
11. Renal Care	• Vitamin D analogues, kidney transplantation, erythropoiesis, iron therapy	
12. Acute care injectibles	• Generics franchise	
13. Other potential areas	• Bbiotech generics (EPO), drug delivery, GI (IBS, constipation, acid suppression)	

ALLOCATION OF PRODUCTS BY THERAPEUTIC AREA - IN MARKETPRELIMINARY

Therapeutic Area	x-Abbott products and projects	x-Knoll products and projects
1. Anti-infectives	Omnicef, Claforan, Biaxin/Klacid, Biaxin/Klacid XL, erythromycin, Metronidazole, Vancomycin, Tosuxacin, Pediazole	erythromycin
2. Anti-viral	Gengraf, Kaletra, Norvir, Certiva, Synagis	
3. Neuroscience	Depakote, Cylert, Gabitril, Depacon, magnesium sulphate, ProSom	Akineton, Cerebrolysin, Exelon, Zoleptil
4. Pain/ inflammation	Tranxene, Fentanyl, Ketorolac, morphine sulfate, A-Hydrocord/ Ampethapred, Actiq	Dilaudid, Vicoprofen, Vicodin, Brufen
5. Cardiovascular/thrombosis	Loftyl, Tricor, Labetalol, Micardis, Digoxin, Diltiazem, Blospres, Simdax	Rythmol, Tarka, Isoptin, Mavik, Gopten/Mavik, Clivarine
6. Urology	Hytrin, Flomax	
7. Diabetes/obesity		Meridia
8. Oncology	Lupron (TAP)	
9. Immunology/ inflammation (including asthma)	Mobic, Avonex, Zylfo (asthma), Xopenex, (asthma), Bremax (asthma)	Hokunalin (asthma)
10. Anesthesia	Ultiva, Ultane/Sevorane, Ethrane, Amideate, Forane, Anzemet, butorphanol, Chirocaine, sufentanil citrate, Atracurium, Tracrium, Nimbox, Nuromax, metoclopramide, Mivacron, Precedex	
11. Renal care	Zemplar, Calcijex	
12. Acute care injectibles	Various generics	
13. Other therapeutic areas	Oxandrin (malnutrition), Thymone (thyroid hormone), Ogen (menopause), Ogastro (ulcers), Prevpac (ulcers), Survanta (lung surfactant), Prevacid (TAP, ulcers)	Chymodiactin (bone regeneration), Iruxol (skin wounds), Synthroid (thyroid hormone), Esberiven (general vascular),

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ALLOCATION OF PRODUCTS BY THERAPEUTIC AREA - PIPELINEPRELIMINARY

Therapeutic Area	x-Abbott Drugs	x-Knoll Drugs
1. Anti-infectives	Spectracef (TAP), ABT-492, ABT-773	HSR-903 (Phase III, Japan)
2. Anti-viral	PETT compounds, Clevudine, DAPD, MIV-606, Coactinon, Coviracil, Synagis, ABT-677, L-FMAU	
3. Neuroscience	Depakote ER, Idebenone, ABS/NPS, ABT-418, MKC-231, Protirelin, TAK-147, ABT-089, ABS-103, NPS-1776	BSF-190555, BSF-201640, BSF-74398
4. Pain	Hydrocodone	Dilaudid CR
5. Cardiovascular/thrombosis	Antexan, TAK-044, ABT-120, Seratrodast, A-74187, ABT-187	Trandolapril, LU-208075, Viprinex, Peg-Hirudin, LU-135252, Rythmol SR (Ludwigshafen projects) BSF-420627
6. Urology	ABT-232, NS-49, ABT-598	
7. Diabetes/obesity	Bimoclomal, ABT-594, Actos, Chrysalin, Voglibose (hyperglycemia)	
8. Oncology	ABT-510, ABT-518, ABT-751, CEP-2563 dihydrochloride, E7010, AGM-1470, CEP-701, TNP-470, YM529, Rubitecan, ABT-627, HMFG1, Theragyn, ABT-828, FTI Backup, TSP-2, Integrin and ICAM modulators	
9. Immunology/ inflammation (asthma)	ABT-963, TAK-603, TMX-67, LJP-394, Atreleuton (asthma), TAK-661 (dermatitis, asthma), VML-530 (asthma)	Thyrogen, J695, D2E7, Segard (all Worcester R&D), Hokunalin tape (asthma)
10. Anesthesia		
11. Renal care		
12. Acute care injectibles	Various generics	
13. Other therapeutic areas	Hextend (hypovolemia), ABT-229 (GERD), EM-574 (gastritis), Risedronate (osteoporosis), Flocor (sickle cell anemia), Broncia (allergic rhinitis), EPO generic program	TU-199 (ulcers), AU-224 (constipation), Ganaton (gastric distmotility), T4/T3 (hypothyroidism)

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MEETING ATTENDEES AND PRESENTERS

Attendees

- A relatively small group of R&D and commercial managers should be present throughout the TA presentations (TA presenters stay throughout or only for their individual TA?)
- Executive session to be held at the end of each day for senior management team (the decision makers)

TA presenters

- Presentations should provide a scientific and commercial review of the potential of each TA
- A mix of expertise will be required to cover major potential issues across R&D and commercial, including
 - Venture heads (GPRD)/Medical Directors (HPD)
 - Franchise heads/Business Unit GMs (HPD)
 - TA heads (research)
- Recommendations on individual presentations
 - Create a single consolidated presentation with Venture Head taking the lead responsibility for pulling it together
 - Divide up the presentation between commercial (market discussion) and technical (unmet needs, pipeline, Abbott position etc)

PROPOSED TEAMS TO DEVELOP TA PRESENTATIONS**PRELIMINARY**

TAs	Primary leader (clinical)	Additional content leaders	Other team members
1. Anti-infectives	• E. Sun	• S. Chang - dis • TBD - comm	• N/a
2. Anti-viral	• E. Sun	• S. Chang - dis • TBD - comm	• n/a
3. Neuroscience	• Iris Loew-Frickel	• J. Sullivan - dis • TBD - comm	• n/a
4. Pain	• Charlie McLeskey (HPD)	• John Heden (HPD) - comm • TBD - dis	• n/a
5. Cardiovascular/ thrombosis	• Suneil Gupta (HPD) • Iris Loew-Friedrich	• F. Frickel - dis • S. Leibold (HPD) - comm • John Toner (HPD) - dis	• Mary Szela (HPD)
6. Urology	• M. Verlinden	• J. Sullivan - dis	• n/a

PROPOSED TEAMS TO DEVELOP TA PRESENTATIONSPRELIMINARY

TAs	Primary leader (clinical)	Additional content leaders	Other team members
7. Diabetes/obesity	• I Loew-Friedrich	• T. Opgenorth - dis • TBD - comm	• N/a
8. Oncology	• P. Nixen/L. Vitek (HPD)	• S. Fesik – dis	• Tom Moore (HPD) - com • Scott Toner (HPD) - com • Dave Ostrow (HPD) - clin
9. Immunology/ immunology	• I Loew-Friedrich • BBC?	• R. Kamen – dis • TBD - comm	• N/a
10. Anesthesia	• Charlie McLeskey (HPD)	• George Maliekal (HPD) - com • TBD - dis	• Mary Szela (HPD) - com • John Toner (HPD) - dis
11. Renal Care	• Bruce McNutt (HPD)	• Susan Rodriguez (HPD) – com	• Loreen Mershimer (HPD)
12. Acute care injectibles	• Laurie Hernandez (HPD)– com/ Jim Raihle (HPD)	• N/a	• N/a
13. Other potential areas (TBD)	• N/a	• Biotech generics (Dave Ostrow – clin) • Critical care (S. Gupta, S. Leibold)	• Critical Care (Mary Szela, John Toner)

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PROPOSED AGENDA - Day 1

~8-9 hrs of presentations/discussion per day

Topic	Presenter/ Facilitator	Timing
Introduction		
• Introduction (Aspirations for the new Abbott Pharma business, meeting objectives, key issues to be resolved)	• Jeff Leiden	• 30 mins
• Review of the overall global pharma opportunity	• TBD	• 2 hrs
– Relative attractiveness of major TAs and disease areas	(McKinsey)	
– Comparison of major regions (US, Europe, Japan)		
– Current position of Abbott relative to competition, in terms of portfolio and capabilities		
Individual TA discussions		
• Anti-infectives	• TA team	• 1.5 hr
Lunch		
• Anti-viral	• TA team	• 1.5 hr
• Neuroscience	• TA team	• 1.5 hr
Executive session	• Jeff Leiden/ McKinsey	• 1.5 hrs

PROPOSED AGENDA - Day 2

Topic	Presenter/ Facilitator	Timing
Individual TA discussions (Continued)		
• Pain/NSAIDS	• TA team	• 1.5 hr
• Cardiology/thrombosis	• TA team	• 1.5 hr
• Urology	• TA team	• 1.5 hr
Lunch		
• Diabetes/obesity	• TA team	• 1.5 hr
• Oncology	• TA team	• 1.5 hr
Executive session	• Jeff Leiden/ McKinsey	• 1.5 hr

PROPOSED AGENDA - Day 3

Topic	Presenter/ Facilitator	Timing
Individual TA discussions (Continued)		
• Immunology (RA, Crohn's, Psoriasis, MS, transplantation, sepsis)	• TA team	• 1.5 hr
• Anesthesia	• TA team	• 1.5 hr
• Renal Care	• TA team	• 1.5 hr
Lunch		
• Acute Care injectibles	• TA team	• 1.5 hr
• Other opportunities (e.g., respiratory, GI, Biotech generics, drug delivery, endocrine, haematology)	• TA team	• 1.5 hr
Executive session	• Jeff Leiden/ McKinsey	• 1.5 hr

PROPOSED AGENDA - Day 4 (HALF DAY EXECUTIVE SESSION)

Topic	Presenter/ Facilitator	Timing
Facilitated discussion on business shape		
<ul style="list-style-type: none"> • Drive to conclusion from Days 1-3 (synthesis from executive sessions) <ul style="list-style-type: none"> -What is the relative attractiveness of the TAs? -How many TAs should Abbott focus on? -What areas of science and what disease should each TA focus on? -What additional technology platforms that we should consider acquiring? -What core areas of discovery and development that need to be upgraded? -What are the licensing needs of each TA? 	<ul style="list-style-type: none"> • TBD (McKinsey?) 	<ul style="list-style-type: none"> • 1.5 hrs
Facilitated discussion of organizational implications		
<ul style="list-style-type: none"> • How should BASF Pharma R and D sites be integrated into Abbott GRPD? • What should be the scope of individual ventures (e.g., neurology/urology and pain)? • What steps can be taken to ensure that cross-TA products are managed effectively (HPD-PPD; devices, etc) • How can the interfaces between research, development and commercial be further improved? 	<ul style="list-style-type: none"> • TBD (McKinsey?) 	<ul style="list-style-type: none"> • 3 hrs
Lunch		

TABLE OF CONTENTS FOR THE R&D STRATEGY RETREAT

Please complete the attached templates (delivering the recommended content is more important than the format) and plan to focus your presentation around the most important pages for your TA. If additional pages are required to emphasize a TA-specific point, limit to 3-5 across the entire presentation. Additional backup can be put into an appendix.

Note that each TA presentation will be limited to 60 minutes, followed by 30 minutes of discussion.

I Executive summary (2 pages):

- Nature of the opportunity for Abbott
- Major R&D recommendations

I Market outlook (5 pages):

- Market drivers over next 10 years
- Epidemiology across major regions
- Current TA sales by disease and drug class
- Major market trends across the TA (to 2010)
- Project market growth by disease area (or drug class)

I Technical outlook (13 pages):

- Disease overview (etiology, pathophysiology)
- Current treatment approaches (drugs, devices, surgery etc)
- Current unmet needs across the TA (prevention, diagnosis, treatment efficacy, safety, compliance)
- Future medical practice (10 years out)
- Challenges and opportunities in discovery, e.g.,
 - Availability of viable targets and technologies
 - Availability of target validation strategies
 - Strength of *in vitro* and *in vivo* models
 - Predictive nature of pre-clinical models
 - Level of discovery expertise at Abbott

- Challenges and opportunities in product development (clinical and regulatory), e.g.,
 - Availability of proof-of-concept trial methodology available
 - Patient recruitment hurdles
 - Availability of clinical trial guidelines
 - Degree of difficulty for trial methodology
 - Validated outcome measures
 - Placebo and comparator response rates
 - Trial cost (size, length complexity)
 - Adverse experience liabilities
 - Level of clinical development expertise at Abbott
 - Regulatory path well established
 - Indication recognized by regulators in US, Europe, Japan
 - Overall regulatory risk of development
 - Level of regulatory expertise at Abbott

¶ **Abbott position (5 pages):**

- Current Abbott sales, portfolio and budget allocation across the TA
- Sales trajectory given current portfolio (to 2010)
- Upside scenario (to 2010)
- Requirements to achieve the upside (resources, in-licensing, infrastructure, etc)